CHAPTER 4 – CLAIMS BILLING OVERVIEW

CHAPTER OBJECTIVE

The objective of this chapter is to provide participants with a thorough understanding of claims filing under the Home Health Prospective Payment System (HH PPS). Information covered in this chapter includes:

1. Review of general information about HH PPS including common acronyms, definitions and legal references

2. Discussion of the major billing changes created by moving to a prospective pay system including the 60-day episode and payment provisions

3. Detailed claim submission instructions and corresponding HCFA-1450/UB-92 examples for filing claims under PPS including situations such as beneficiary transfers and changes in condition

At the conclusion of this chapter, participants will have working knowledge of claims filing that will enable them to complete and submit HCFA-1450/UB-92 claims for covered home health services provided under PPS.

HH PPS GENERAL INFORMATION

HH PPS Defined

A prospective payment system that applies to all Medicare-covered home health services (including supplies) provided to beneficiaries under the Medicare home health benefit. HH PPS becomes effective for all home health agencies with cost reporting periods on or after October 1, 2000.

HH PPS Legal Authorization

Section 4603(a) of the Balanced Budged Act (BBA) of 1997 amended the Social Security Act by adding Section 1895, titled *Prospective Payment for Home Health Services*. Section 1895 was further amended by Section 5101(c) of the Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA) of 1999. Section 1895(a) now states that "the Secretary shall provide for portions of cost-reporting periods occurring on or after October 1, 2000, for payments for home health services in accordance with the Prospective Payment System…" Section 1895(b) requires all Medicare services covered and paid on a reasonable cost basis under the Medicare home health benefit to be paid on the basis of a prospective payment amount.

MAJOR CHANGES UNDER HH PPS

Case-Mix System

The system used for HH PPS is a method of combining 20 data elements to measure three dimensions of case-mix:

- clinical severity factors
- functional status factors
- service utilization factors

Grouper Software Built into the HAVEN Software, Used for Transmission of OASIS Data to the State, is Used to Determine the Health Insurance Prospective Payment System Code (HIPPS Code).

The system defines a set of 80 **Home Health Resource Groups (HHRGs)** from all possible combinations of severity levels across the three dimensions. Beneficiaries are grouped into the appropriate case-mix group based on patient data from the **Outcome and Assessment Information Set (OASIS)** collected at the HHA including one additional patient-specific item regarding number of therapy hours received in the 60-day episode. Grouper software built into the HAVEN software, which is used for transmission of OASIS data to the state, is used to determine the **Health Insurance Prospective Payment System Code (HIPPS Code)**.

HIPPS Codes

The following coding scheme has been developed to create a 5-position alphanumeric HIPPS Code (e.g., HAEJ1) to represent HHRGs for Medicare payment, using a new position to denote whether any of the assessment information had to be derived.

- The first position will always be an “H”.
- The second, third and fourth positions of the code will correspond to the HHRGs.
- The fifth position will indicate what elements of the code were computed or derived.

See table on next page.

The HHRG system is published in the HH PPS final rule with identifiers (codes) that express the payment groups in terms of the clinical, functional and service domains of the OASIS. For instance, an identifier of C0F0S0 represents the minimum score in all three domains. The chart below can be used to crosswalk an identifier to a HIPPS codes.

(Clinical) Position #2	(Functional) Position #3	(Service) Position #4	Position #5	Domain Level
A (C0)	E (F0)	J (S0)	1 = all positions computed	= min
B (C1)	F (F1)	K (S1)	2 = 2nd position derived	= low
C (C2)	G (F2)	L (S2)	3 = 3rd position derived	=mod
D (C3)	H (F3)	M (S3)	4 = 4th position derived	= high
	I (F4)		5 = 2nd & 3rd positions derived	= max
			6 = 3rd & 4th positions derived	
			7 = 2nd & 4th positions derived	
			8 = 2nd, 3rd & 4th positions derived	
		N thru Z	9, 0	expansion values

Indicate the HIPPS Code on Transactions you Submit to your Regional Home Health Intermediary (RHHI) Using Revenue Code 0023

Indicate the HIPPS Code on transactions you submit to your Regional Home Health Intermediary (RHHI) using Revenue Code 0023. More information about placing the HIPPS Code on transactions submitted to the RHHI can be found in the Submission Instructions section, which appears later in this chapter.

60-day Episode

Payment is no longer made by the service or visit under HH PPS. The basic unit of payment for HH PPS is a 60-day episode. The 60-day episode corresponds with the OASIS and the current Medicare Plan of Care certification requirements.

The 60-day episode **begins** with the first Medicare billable visit as day 1 and **ends** on and includes the 60th day from the start of care date. **Recertification** begins on day 61 and ends on and includes day 120, etc. There is no limit to the number of 60-day episode recertifications in a given fiscal year, provided that the beneficiary is eligible for continued medically necessary home health services.

The 60-day episode covers a beneficiary for 60 days of care regardless of the number of days of care actually furnished during that episode unless one of the following intervening events occurs:

Beneficiary Elected Transfer

If the beneficiary elects to transfer to another HHA (that is not sharing common ownership with the HHA), the 60-day payment episode ends.

> ***Transfer Example:*** *The beneficiary is treated by HHA-1 Day 1 through day 30 of a 60-day episode. The beneficiary elects to transfer to HHA-2 on day 35. Day 30 was the last billable visit provided by HHA-1 under the original Plan of Care. A new 60-day episode begins on day 38 because day 38 is the first ordered visit under the new Plan of Care. Day 38 becomes Day 1 in the new episode established by HHA-2.*

Beneficiary Discharge/Return to HHA within 60-day Episode

If the beneficiary is discharged because treatment goals are met, the 60-day episode ends even if the

beneficiary returns to the HHA during the same 60-day episode. The original Plan of Care must be terminated because there is no anticipated need for additional home health services for the balance of the 60-day episode.

> ***Discharge Example:*** *The beneficiary is discharged on Day 20 because treatment goals in the original Plan of Care were met. The beneficiary returns to the same HHA on Day 35. The first Medicare billable service under the new OASIS assessment and Plan of Care occurs on Day 40 of the original episode. Day 40 of the original episode becomes Day 1 of the newly certified episode and Day 20 ends the original episode.*

Note that if a beneficiary enters the hospital and does not return by the end of the 60-day episode, the HHA is reimbursed for the entire 60-day episode. If the beneficiary has not returned at the end of the episode, the beneficiary should be discharged.

Beneficiary Experiences Significant Change in Condition

If the beneficiary experiences a **Significant Change in Condition (SCIC)**, which was not anticipated in the original Plan of Care as part of the expected course of the beneficiary's response to treatment, it results in a new case-mix assignment. The 60-day episode continues, and the new HIPPS Code and the date of the assessment are noted on the claim along with the original HIPPS code. Note that multiple SCIC adjustments are permitted in a 60-day episode, though few instances of multiple SCIC adjustments in a single episode are expected.

> ***SCIC Example:*** *The beneficiary is being treated for congestive heart failure and falls in the home, which results in a hip fracture and a hospital stay. The fall happens 5 days after admission to the HHA. The beneficiary is discharged from the hospital on the 45th day of the 60-day episode and resumes care. A new OASIS assessment can be*

completed that will most likely result in a change in the case-mix assignment. Note that this home health claim would not be considered a discharge and return to the same HHA and it would not be considered an end to the 60-day episode. The 60-day episode would continue under the new case-mix assignment and this new HIPPS code information would be noted on the claim along with the original HIPPS code.

Payment Provisions

PEP and SCIC Adjustments

The Original 60-Day Episode Ends if the Beneficiary Elects a Transfer or is Discharged and then Subsequently Returns to the HHA Within the Same 60-Day Episode

The original 60-day episode ends if the beneficiary elects a transfer or is discharged and then subsequently returns to the HHA within the same 60-day episode. When the beneficiary transfers or is discharged and then re-admitted, payment is proportionally adjusted to reflect the actual length of time the beneficiary was in the care of the HHA. This proportional payment is called a **Partial Episode Payment Adjustment (PEP Adjustment)**.

> ***Pep Adjustment Example:*** *A beneficiary is assigned to an HHRG for which payment is $3,000. The beneficiary elects to transfer to another HHA on Day 35. The first service was provided on the first day of the episode. The last billable service provided by the initial HHA before the transfer occurred on Day 30. This is the end of the 60-day episode. The initial HHA receives a proportionally adjusted payment to reflect the length of time the beneficiary remained under its care. It would receive a PEP Adjustment equal to 30/60 ($1,500 out of $3,000).*

The original 60-day episode continues when the beneficiary experiences a SCIC

The original 60-day episode continues when the beneficiary experiences a SCIC. Payment is proportionally adjusted to reflect the time both prior and after the beneficiary experienced a SCIC during the 60-day episode. This payment is called a **SCIC Adjustment**.

> ***SCIC Adjustment Example****: A beneficiary is assigned to an HHRG for which payment is $2,000. The beneficiary experiences a SCIC on Day 21. The first service was provided on the first day of the episode. The last billable service date prior to the SCIC is Day 20. The HHA completes an OASIS assessment, obtains the necessary physician change orders to alter the course of treatment in the Plan of Care, and Grouper assigns the beneficiary to a new HHRG for which*

payment is $4,000. The first service provided under the revised Plan of Care occurs on Day 25. Two calculations will occur to generate the SCIC Adjustment amount: the span of days used to calculate the first part of the SCIC Adjustment, Days 1 through 20 (20/60 x $2,000 = $666.67), and the span of days used to calculate the 2nd part of the SCIC Adjustment, Days 25 through 60 (36/60 x $4,000 = $2,400). Remember that Day 25 was the day the first billable service was provided under the revised Plan of Care. Day 60 is the date of the last billable service. Reimbursement from the SCIC Adjustment totals $3,066.67 ($666.67 + $2,400).

LUPAs

If an HHA provides four or fewer visits during the 60-day episode, it receives a **Low Utilization Payment Adjustment (LUPA)** reflecting a national average per-visit payment by discipline for the visits actually provided during the episode. PEP Adjustments and SCIC adjustments can be further adjusted if a LUPA applies. Pricer software, embedded in the standard systems, will execute all these payment adjustments, as will determine whether a LUPA applies first, and them make PEP and SCIC adjustments.

Split Payments

When an initial, processable **Request for Anticipated Payment (RAP)** is submitted, the HHA receives a payment equal to 60% of the estimated case-mix adjusted episode payment. When a processable claim is submitted for that 60-day episode, the HHA receives a final payment equal to 40% of the actual case-mix adjusted episode. Payments are subject to PEP Adjustments, SCIC Adjustments or LUPAs.

On subsequent recertifications, the HHA will receive payment in a 50/50 split. When a processable RAP is submitted for the next 60-day recertified episode, your HHA receives a payment equal to 50% of the

estimated case-mix adjusted episode payment. When the claim is submitted for that 60-day recertified episode, the HHA receives a final payment equal to 50% of actual case-mix adjusted episode. Payments are subject to PEP Adjustments, SCIC Adjustments or LUPAs.

Outlier Payment

- **Where HHA Incurs Extraordinary Costs Beyond Regular Episode Payment**

Outlier Payments

In situations where the HHA incurs extraordinary costs beyond the regular episode payment, an outlier payment may be made. The outlier threshold for each HHRG is defined as the 60-day episode payment for the HHRG plus a fixed dollar loss amount that is the same for all case-mix groups. Pricer software will execute outlier calculations automatically, though outliers will not apply when paid on a LUPA basis.

Consolidated Billing

The HHA establishing the HH Plan of Care has the responsibility for billing all Medicare-covered home health services. The services subject to consolidated billing are:

- part-time or intermittent skilled nursing care
- part-time or intermittent home health aide services
- physical therapy
- speech language pathology
- occupational therapy
- medical social services
- routine and non-routine medical supplies (a review list of non-routine medical supplies is included at the end of this chapter; these items are included in the PPS episode payment)
- a covered osteoporosis drug, but excluding other drugs and biologicals (billed under bill type 34X; not paid under the PPS rate)
- Medical services provided by an intern or resident-in-training of a hospital

- Services at hospitals, skilled nursing facilities or rehabilitation centers when they involve equipment too cumbersome to bring to the home

HHAs will no longer be able to "unbundle" services to an outside supplier. The HHA has to furnish the home health services either directly or under arrangement with an outside supplier, and the HHA itself, rather than the supplier, must bill Medicare. The Common Working File (CWF) will monitor and reject any transactions that are not billed by the primary HHA.

This means, for example, that a hospital billing outpatient services for a beneficiary already under an HH Plan of Care must work with the HHA that established the 60-day episode on CWF in order to get paid for those services. The hospital will not get paid for the outpatient services if the HHA is not the agency submitting the claim for services. If a beneficiary is under an HH Plan of Care, all services must be billed by the HHA. For more information, review the Transaction Matrix at the end of this chapter, which explains how PPS impacts other providers.

Durable Medical Equipment (DME)

HHAs may continue to bill the RHHI for DME using the UB-92 (HCFA-1450), except for sub-units that bill the Durable Medicare Equipment Regional Carriers (DMERCs) directly as suppliers. Any DME provided to a beneficiary covered under the Medicare home health benefit must be included on the claim (TOB 329) or billed as a medical/other health service (TOB 34X). A line item date of service is required for all DME/Oxygen line items. If the item being billed is a rental item, the delivery date should be used as the line item date.

Note that DME is a service paid on a fee schedule basis when covered under the Medicare home health benefit. DME will continue to be paid under the DME fee schedule. A separate payment amount based on

the DME fee schedule will be made for DME covered as a home health service under PPS.

SUBMISSION INSTRUCTIONS

For most 60-day episodes (including re-certified episodes), the HHA will submit a **RAP** and a **Claim**. When submitting RAPs and Claims, **transactions must be processed sequentially** within the 60-day episode. The RAP must be processed by the RHHI prior to submission of the claim.

In Some Situations, the HHA Will Not Have to Submit a Rap

In this situation, the claim is called a No-RAP-LUPA Claim

In some situations, the HHA will not have to submit a RAP. If it determines before submitting the RAP that the beneficiary will receive (or has received) 4 or fewer visits during an episode, the HHA may submit a claim without submitting a RAP. For example, if the beneficiary elects to transfer to another HHA after receiving only 2 visits from the HHA, and it has not yet submitted the RAP, it is acceptable for the HHA to submit a Claim without first submitting a RAP. In this situation, the claim that the HHA submits is called a **No-RAP-LUPA Claim**. The HHA must have signed physician orders before you submit the No-RAP-LUPA Claim. The only situation in which a claim can be submitted without first submitting a RAP involve beneficiaries receiving 4 or fewer visits during a 60-day episode, and this type of claim is called a No-RAP-LUPA.

Submission Changes to Note

- For a RAP, a No-RAP-LUPA claim, or a claim, the 2nd digit of the type of bill can **always** be the number 2 (e.g., 322, 327, 328, 329). The number 3 no longer needs to be used as the 2nd digit in this type of bill (e.g., 332). It is still acceptable, however, to use the number 3 as the 2nd digit in the type of bill. Continue to use type of bill 34X, where 4 is the 2nd digit, when billing outpatient services.

RAPS will be Automatically Cancelled, and the Payment Recouped, if the Claim is Not Submitted Within 60 Days of the End of the Episode or 60 Days From the Issuance of the Anticipated Payment, Whichever is Greater

- Verbal orders are required before submitting a RAP. A physician-signed Plan of Care is not necessary before RAP submission; however, physician-signed orders must be obtained as soon as possible, and before submission of the claim.

- Because the RAP is considered a "request for anticipated payment" rather than a claim, RAPs will be automatically cancelled, and the payment recouped, if the claim is not submitted within 60 days of the end of the episode or 60 days from the issuance of the anticipated payment, whichever is greater.

- RAPs can be cancelled, and claims can be adjusted or cancelled; however, add-on charges submitted on 3X5 types of bills are no longer allowed. If there is an add-on charge, the HHA must adjust the claim.

A New Patient Status Code (Ub-92 Form Locator 22), 06, is Available

- A new patient status code (UB-92 Form Locator 22) of 06, is available. Patient status code 06 will be used on a final claim when the beneficiary has transferred from one agency to another HHA and when the patient is discharged prior to the end of the 60-day episode and the HHA knows the patient will be readmitted within the same 60-day period.

- The Source of Admission (UB-92 Form Locator 20) is now required on all bill types. Valid Source of Admission codes include:
  - B - Transfer from another HHA
  - C - Readmission to same HHA
  - 1 - Physician Referral
  - 2 - Clinic Referral
  - 3 - HMO Referral
  - 4 - Transfer from a Hospital facility
  - 5 - Transfer from a SNF
  - 6 - Transfer from another health care facility
  - 7 - Emergency Room
  - 8 - Court/Law enforcement
  - 9 - Information not available

- Occurrence code 27 (HHA cert/recert date) and occurrence span code 74 (inpatient stay) do not need to be submitted on RAPs or claims.

- Charges for revenue codes 058X and 059X cannot be billed as covered on 32X and 33X types of bills.

The OASIS Matching Key is required on all RAPs, No-RAP-LUPA Claims and Claims.

- The OASIS Matching Key required on all RAPs, No-RAP-LUPA claims, and claims. This information should be entered in the Treatment Authorization Code field (FL 63). This information is composed of three items from the assessment. It will be an eighteen position code, containing the start of care date (M0030), the date the assessment was completed (M0090) and the reason for assessment (M0100). These three data elements must come from the OASIS assessment used to produce the HIPPS code on the claim.

- If there is a provider number change between submission of the RAP and the claim, the HHA must end the current 60-day episode by submitting a claim with the old provider number. This should be submitted at the time of provider number change. Then the HHA will submit a RAP with the new provider number, which will begin a new 60-day episode under the new provider number.

Checking Eligibility

Prior to submitting a RAP, HHAs and hospice agencies with electronic access should verify the beneficiary's eligibility by accessing HIQH, which is the new HHA provider inquiry screen for eligibility. The provider will be able to view:

- Health Insurance Claim Number
- Medicare entitlement dates
- Medicare secondary payer information
- HMO information

- HH PPS episode data (start & end date and provider number)
- HH benefit period data
- Hospice benefit period data

The episode and benefit period data will indicate if the beneficiary is already in a 60-day episode with another HHA. There is the option of entering a date to check specific episode periods. The two episodes closest to that date will appear on the screen. If no date is entered, the system will display the two most recent episodes. Up to 36 episode iterations will be stored, but only two will display on the screen at any given time. To see additional episodes, the F5 and F6 keys allow the user to scroll forward and backward.

If the beneficiary is already in a 60-day episode with another HHA, the provider will need to contact the HHA holding the open episode record to coordinate services. You may call your RHHI to get the name and address of the agency associated with the provider number on HIQH. If the beneficiary is already in a 60-day episode with another HHA and is transferring, the receiving agency will submit a RAP indicating a transfer as outlined in the section below. In addition, refer to the Transaction Matrix at the end of this chapter, which explains how CWF is impacted by PPS transactions submitted to the RHHI.

Request for Anticipated Payment

A RAP, which is not subject to the payment floor, is submitted at the beginning of each 60-day episode unless a known LUPA situation is present. If a known LUPA situation is present, the HHA is not required to submit a RAP and can submit a No-RAP-LUPA Claim instead. For more information about LUPAs, refer to the beginning of the Submission Instructions section in this chapter.

In addition to containing basic beneficiary information, the RAP must include the HIPPS code generated from the Grouper software and revenue code 0023.

The total charge for the 0023 revenue code line will equal zero. The total charges on the RAP on revenue code line 0001 will equal zero. No other line item data needs to be included on the RAP. If, however, the HHA needs to include other line item data on the claim because its software requires a total charge greater than zero, it is acceptable to do so. When additional line item data appears on an incoming RAP, the system will ignore this data and look only at the HIPPS code information in order to generate payment. The system will automatically insert the reimbursement amount in the 0023 and 0001 total charges fields.

If the RAP goes into a Medical Review or MSP Location, the Claim Cannot be Processed Until the RAP Processes

RAPs will be subject to medical review and Medicare Secondary Payer (MSP) review; therefore, it is imperative for the RAP to be submitted in a timely manner. If the RAP goes into a medical review or MSP location, the claim cannot be processed until the RAP processes.

Submitting a RAP

The following form locators (FLs) are required when submitting a RAP. Pay particular attention to those FLs that are shaded.

ⓘ The EMC Version 6.0 Record Type (RT) indicator has been included next to the UB-92 FLs. For claims using third-party software, the vendor may be interested in the RT information. Note that although RT indicators for EMC Version 5.0 have not been included, FIs will continue to accept EMC Version 5.0 until January 1, 2001. With EMC Version 5.0, the number of allowed revenue code lines is 297. With EMC Version 6.0, the number of allowed revenue code lines is 450.

FL 1 **Untitled** (RT 10)	Enter the agency name and address.
FL 4 **Type of Bill** (RT 40)	Enter 322.
FL 6 **Statement Covers Period "From" and "Through" Dates** (RT 20)	**Initial RAP:** Enter the effective date of admission, which is the first Medicare billable visit and the Medicare start of care date in the "from" field. Enter the same date in the "through" field. **Subsequent Episode RAP:** Enter the first date of the newly certified episode in the "from" field (e.g., day 61, day 121, day 181, etc.). Enter the same date in the "through" field.
FL 12 **Patient Name** (RT 20)	Enter the beneficiary's last name, first name and middle initial as it appears on the Medicare health insurance card.
FL 13 **Patient Address** (RT 20)	Enter the beneficiary's address including street number and name of post office box or RFD, city, state, and zip code.
FL 14 **Birth Date** (RT 20)	Enter the beneficiary's date of birth in a MMDDCCYY format.
FL 15 **Patient Sex** (RT 20)	Enter M for male or F for female.
FL 17 **Admission Date** (RT 20)	Enter the effective date of admission, which is the first Medicare billable visit and the Medicare start of care date.

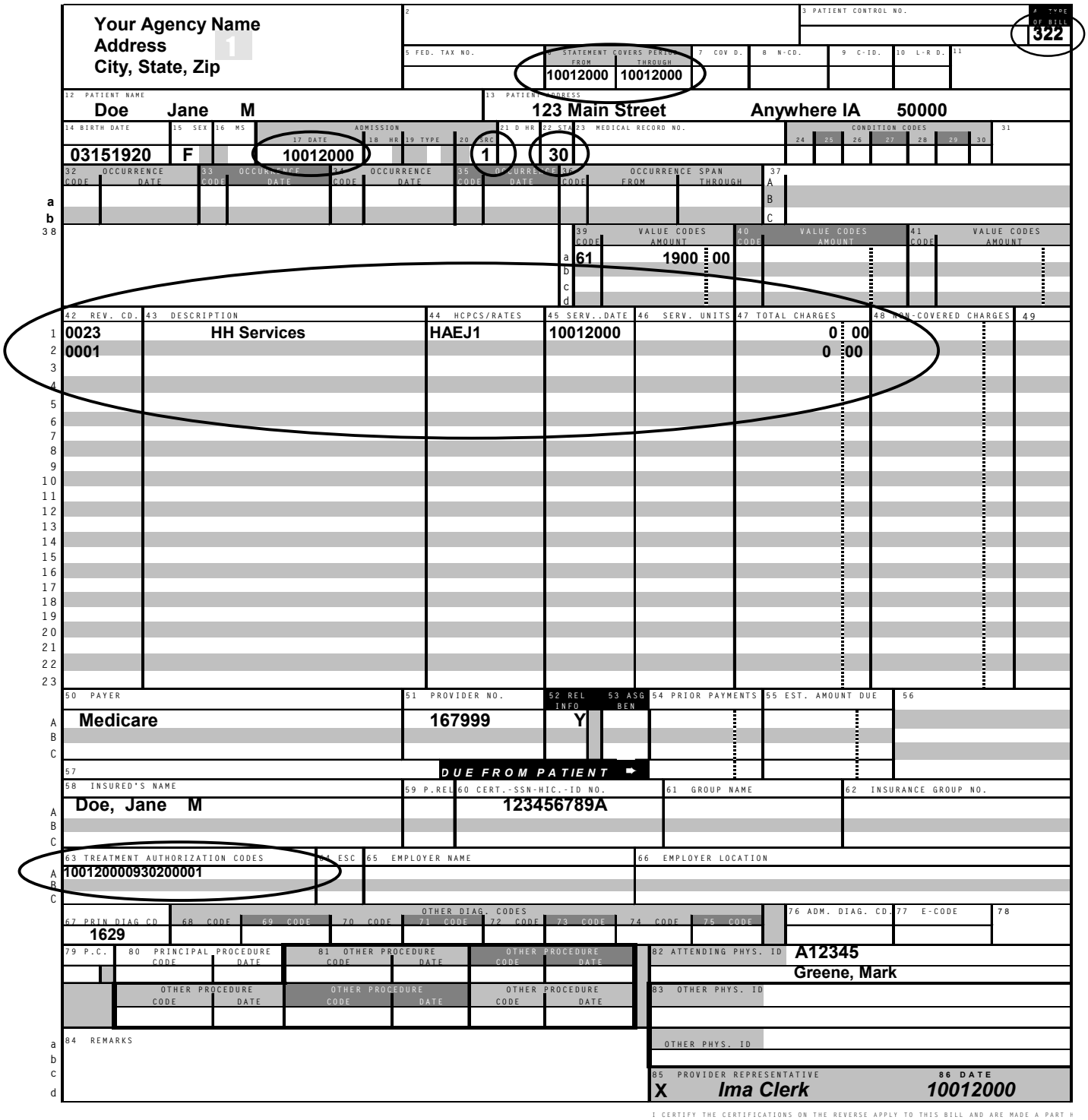
FL 20 **Source of Admission** (RT 20)	Enter **B** if this beneficiary transferred to your HHA from another HHA. Enter **C** if this beneficiary was discharged and readmitted to your HHA within a 60-day episode. If this is not a transfer situation or a discharge/readmit situation, enter the appropriate source of admission code.
FL 22 **Patient Status** (RT 20)	Enter a patient status code of 30. No other patient status codes are acceptable.
FL 39-41 **Value Code(s)** (RT 41)	Enter a value code of 61 with the appropriate Metropolitan Statistical Area (MSA) code. Be sure to include the appropriate trailing zeros to make it 6 digits in length (e.g., if the MSA code is 1900, enter 190000).
FL 42 **Revenue Code** (RT 61)	Enter revenue code 0023, which indicates that a HIPPS code is present, and revenue code 0001. If other revenue codes need to be submitted because of software constraints, enter those codes.
FL 44 **HCPCS/Rates** (RT 61)	Enter the HIPPS Code that was generated from the Grouper software on all line items for revenue code 0023. If you are entering other revenue codes, include the appropriate HCPCS/rates.
FL 45 **Service Date** (RT 61)	Enter the first billable service date. If you are entering other line items, include the applicable service date(s).

FL 47 Total Charges (RT 61)	The total charge for the 0023 line will be zero. If other charges are added to comply with your software, enter the correct total charges for those charges in the 0001 total charges field; otherwise, enter a zero dollar amount in that field.
FL 50 Payer Identification (RT 30)	If Medicare is the primary payer, enter Medicare on line A. Enter other insurance payers on line B, if secondary, and line C, if tertiary.
FL 51 Provider Number (RT 10)	Enter your HHA provider number.
FL 52 Release of Information (RT 30)	A "Y" code indicates that your HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims. An "R" code indicates the release is limited or restricted. An "N" code indicates no release is on file.
FL 58 Insured's Name (RT 30)	Enter the name shown on the Medicare health insurance identification card. Enter the last name first using a comma or space to separate the first name from the last name.
FL 60 Cert./SSN/HIC/ID NO. (RT 30)	Enter the Medicare health insurance claim number as shown on the Medicare health insurance card.
FL 63 Treatment Authorization Code (RT 40)	**New Required Field:** Enter the OASIS matching key that is eighteen positions derived from the M0030, M0090, M0100.

FL 67 **Principal Diagnosis Code** (RT 70)	Enter the principal diagnosis for which the beneficiary is receiving home health services. Be sure to use the code from the most recent coding publication. The information in this field must match the principal diagnosis indicated on the HCFA-485 and OASIS assessment.
FL 68-75 **Other Diagnosis Codes** (RT 70)	Enter any other diagnosis codes for which the beneficiary was treated during this period of care. The information in this field must match the diagnosis indicated on the HCFA-485 and OASIS assessment.
FL 82 **Attending Physician ID** (RT 80)	Enter the Unique Physician Identification Number (UPIN) of the physician who has primary responsibility for the beneficiary's medical care and treatment, and the physician's last name and first initial.
FL 85 **Provider Representative**	An HHA representative must ensure that the record is accurate before signing and dating this form. A stamped signature is acceptable.

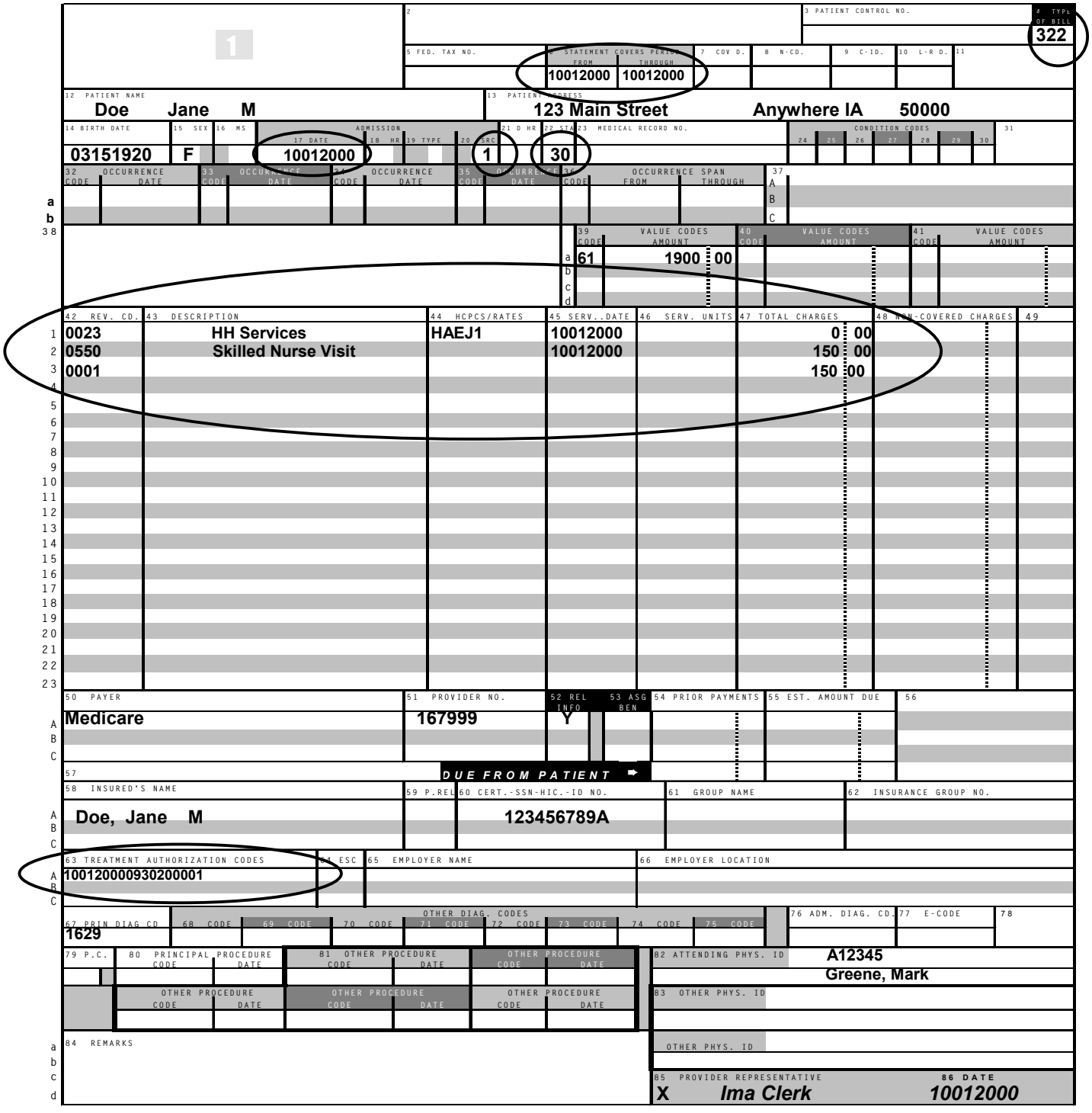
Refer to the following pages for examples of RAPs.

RAP - Non-Transfer Situation



RAP - Non-Transfer Situation w/ Line Item Service Added

This is an example of what a RAP might look like if other line item data had to be added because your software required a total charge greater than zero on the UB-92. The system will look only at the HIPPS Code information in order to generate payment. Remember that you will also need to enter this line item data on the Claim. That is, in this example, your claim would also contain the charge for the Skilled Nursing visit on 10/01/2000.



1	0023	HH Services	HAEJ1	10012000		0	00	
2	0550	Skilled Nurse Visit		10012000		150	00	
3	0001					150	00	

1 — 3 PATIENT CONTROL NO.: 322

6 STATEMENT COVERS PERIOD: FROM 10012000 THROUGH 10012000

12 PATIENT NAME: Doe Jane M

13 PATIENT ADDRESS: 123 Main Street Anywhere IA 50000

14 BIRTH DATE: 03151920 | 15 SEX: F | 17 ADMISSION DATE: 10012000 | 20 SRC: 1 | 22 STAT: 30

39 VALUE CODES AMOUNT: a 61 1900 00

50 PAYER: Medicare | 51 PROVIDER NO.: 167999 | 52 REL INFO: Y

57: DUE FROM PATIENT

58 INSURED'S NAME: Doe, Jane M | 60 CERT.-SSN-HIC.-ID NO.: 123456789A

63 TREATMENT AUTHORIZATION CODES: 100120000930200001

67 PRIN DIAG CD: 1629

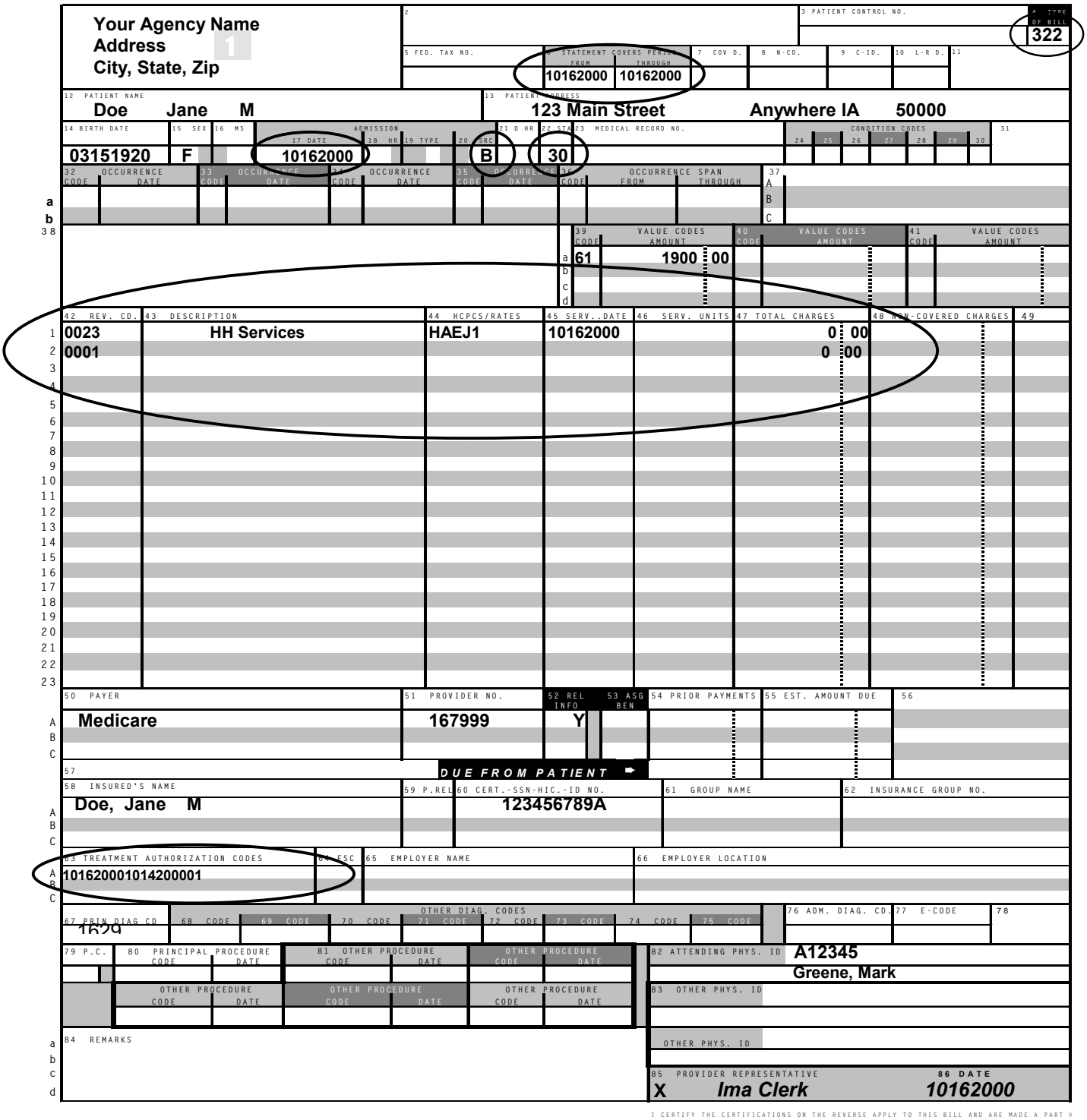
82 ATTENDING PHYS. ID: A12345 Greene, Mark

85 PROVIDER REPRESENTATIVE: X Ima Clerk | 86 DATE: 10012000

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

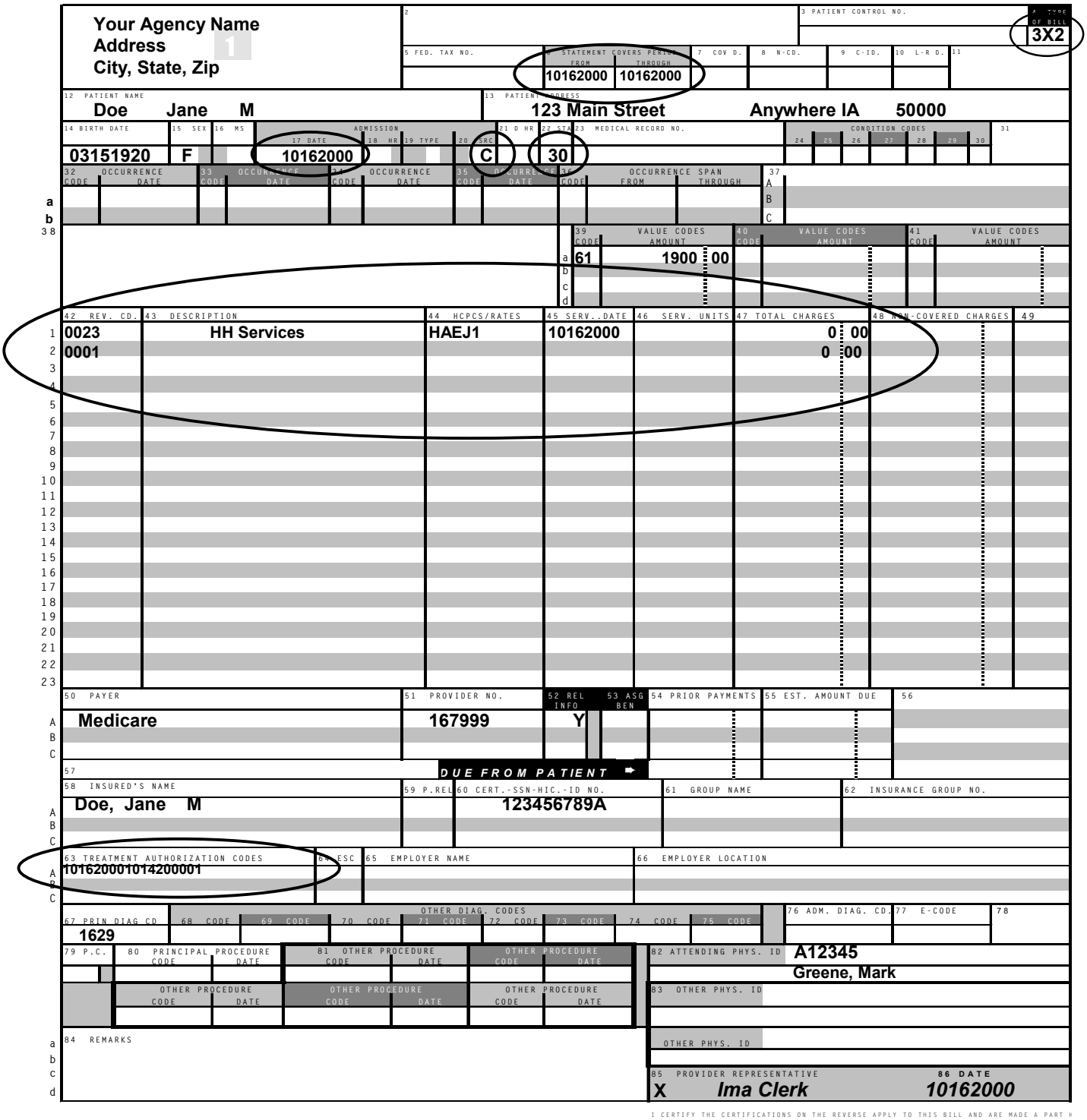
RAP - Transfer Situation

Note Source of Admission (FL 20) is a B, which indicates that this beneficiary transferred to your HHA from another HHA.



RAP - Discharge/Re-Admit

Note Source of Admission (FL 20) is a C, which indicates that this beneficiary was discharged from your HHA, but was readmitted within the same 60-day episode.



Canceling a RAP

If an incorrect HIPPS code is entered on a RAP, the HHA must cancel the RAP and submit a new RAP with the corrected information. The RAP can be cancelled only if the claim has not already been submitted. Note that canceling a RAP also cancels the episode on CWF. For more information about how PPS transactions impact CWF, refer to the Transaction Matrix at the end of this chapter.

If the HIPPS code was entered incorrectly on the RAP and on the claim, it is the claim that must be adjusted. Adjusting the claim will eliminate the need for any adjustment or cancellation to the RAP itself.

The following form locators (FLs) are required when canceling a RAP. Pay particular attention to those fields that are shaded.

FL 1 **Untitled** (RT 10)	Enter the agency name and address.
FL 4 **Type of Bill** (RT 40)	Enter 328.
FL 6 **Statement Covers Period "From" and "Through" Dates** (RT 20)	Enter the appropriate "from" and “through” date. Make sure this matches the original RAP.
FL 12 **Patient Name** (RT 20)	Enter the beneficiary's last name, first name and middle initial as it appears on the Medicare health insurance card.
FL 13 **Patient Address** (RT 20)	Enter the beneficiary's address including street number and name of post office box or RFD, city, state, and zip code.

FL 14 **Birth Date** (RT 20)	Enter the beneficiary's date of birth in a MMDDCCYY format.
FL 15 **Patient Sex** (RT 20)	Enter M for male or F for female.
FL 17 **Admission Date** (RT 20)	Enter the effective date of admission. Make sure this matches the original RAP.
FL 20 **Source of Admission** (RT 20)	Enter the appropriate source of admission code, which should match the source of admission code on the original RAP.
FL 22 **Patient Status** (RT 20)	Enter a patient status code of 30. No other patient status codes are acceptable.
FL 24-30 **Condition Codes** (RT 41)	Enter the appropriate claim change reason code: D5 - cancel to correct HICN or provider number; D6 - cancel duplicate or OIG overpayment.
FL 37 **Internal Control Number or Document Control Number** (RT 31)	Enter the Intermediary's control number on the claim being canceled. This number can be found on the remittance advice listing the original processed RAP.
FL 39-41 **Value Code(s)** (RT 41)	Enter a value code of 61 with the appropriate Metropolitan Statistical Area (MSA) code. Be sure to include the appropriate trailing zeros to make it 6 digits in length (e.g., if the MSA code is 1900, enter 190000). Enter other value codes as applicable.

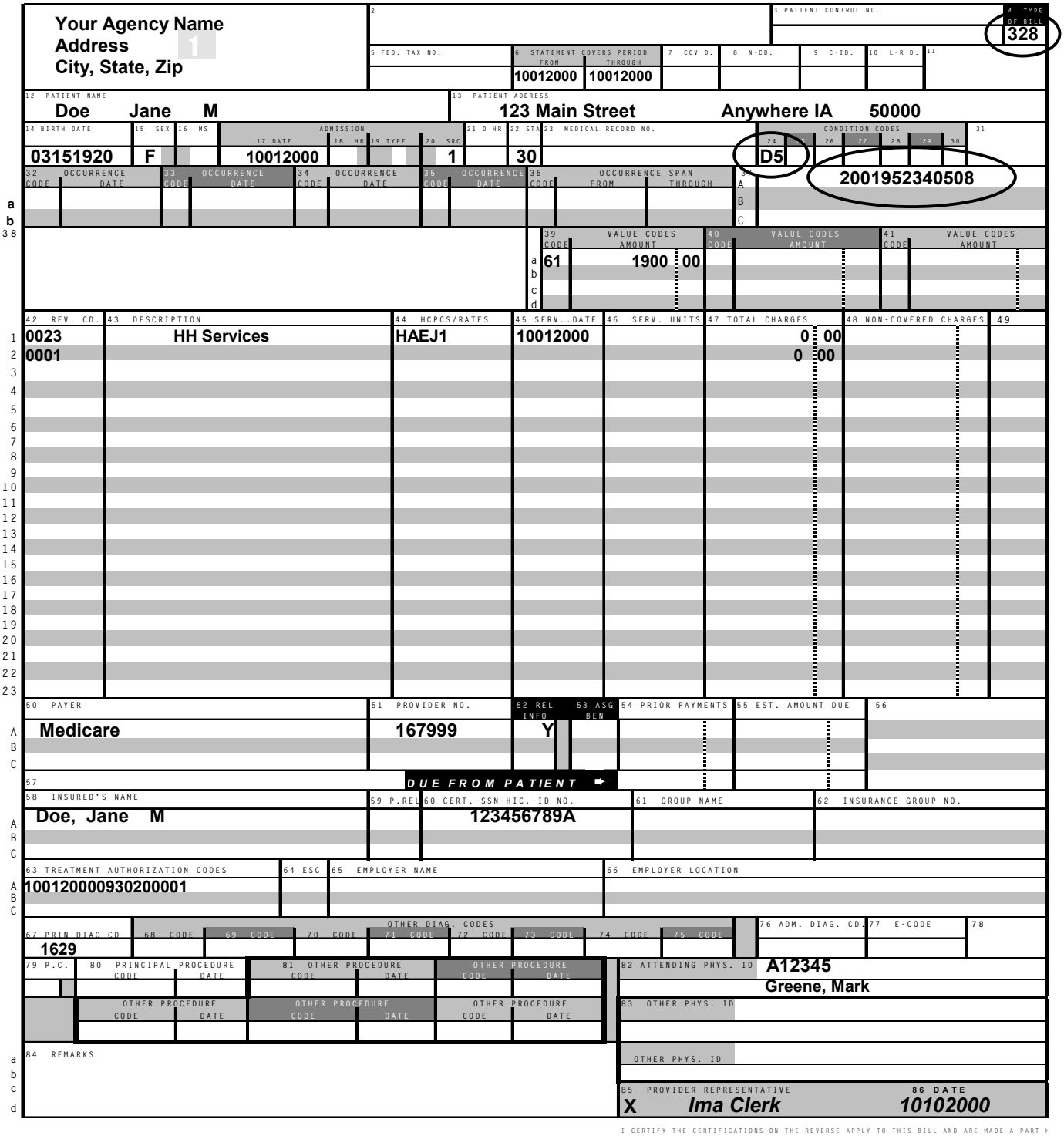
FL 42 **Revenue Code** (RT 61)	Enter revenue code 0023, which indicates that a HIPPS code is present, and revenue code 0001. If other revenue codes were added, include these on the RAP. Make sure the revenue code page matches the original RAP.
FL 44 **HCPCS/Rates** (RT 61)	Enter the HIPPS Code that was generated from the Grouper software. If other information was added, make sure the revenue code page matches the original RAP.
FL 45 **Service Date** (RT 61)	Enter the first billable service date. Make sure this matches the original RAP.
FL 47 **Total Charges** (RT 61)	The total charge for the 0023 line will be zero. If other charges were added to comply with your software, enter the correct total charges for those charges on revenue code line 0001. Make sure this matches the original RAP.
FL 50 **Payer Identification** (RT 30)	If Medicare is the primary payer, enter Medicare on line A. Enter other insurance payers on line B, if secondary, and line C, if tertiary.
FL 51 **Provider Number** (RT 10)	Enter your HHA provider number.
FL 52 **Release of Information** (RT 30)	A "Y" code indicates that your HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims. An "R" code indicates the release is limited or restricted. An "N" code indicates no release is on file.

FL 58 Insured's Name (RT 30)	Enter the name shown on the Medicare health insurance identification card. Enter the last name first using a comma or space to separate the first name from the last name.
FL 60 Cert./SSN/HIC/ID NO. (RT 30)	Enter the Medicare health insurance claim number as shown on the Medicare health insurance card.
FL 63 Treatment Authorization Code (RT 30)	**New Required Field:** Enter the OASIS matching key that is eighteen positions derived from the M0030, M0090, M0100.
FL 67 Principal Diagnosis Code (RT 70)	Enter the principal diagnosis for which the beneficiary is receiving home health services. This will match the original RAP.
FL 68-75 Other Diagnosis Codes (RT 70)	Enter any other diagnosis codes for which the beneficiary was treated during this period of care. This will match the original RAP.
FL 82 Attending Physician ID (RT 80)	Enter the Unique Physician Identification Number (UPIN) of the physician who has primary responsibility for the beneficiary's medical care and treatment, and the physician's last name and first initial.
FL 85 Provider Representative	An HHA representative must ensure that the record is accurate before signing and dating this form. A stamped signature is acceptable.

Refer to the following page for an example of canceling a RAP.

RAP - Cancellation

Note that the type of bill changes to end in an 8, a Claim Change Reason Code (e.g., D5) is included, and the RHHI's Internal Control Number that identified the original RAP is included.



Your Agency Name
Address
City, State, Zip

TYPE OF BILL: 328

FED. TAX NO. | STATEMENT COVERS PERIOD: FROM 10012000 THROUGH 10012000

PATIENT NAME: Doe Jane M
PATIENT ADDRESS: 123 Main Street Anywhere IA 50000

BIRTH DATE	SEX	ADMISSION DATE	HR	TYPE	SRC	D HR	STAT	MEDICAL RECORD NO.	CONDITION CODES
03151920	F	10012000			1		30		D5

2001952340508

OCCURRENCE CODE / DATE; OCCURRENCE SPAN CODE / FROM / THROUGH

VALUE CODES: 39 CODE 61 AMOUNT 1900 00; 40 CODE; 41 CODE

	REV. CD.	DESCRIPTION	HCPCS/RATES	SERV. DATE	SERV. UNITS	TOTAL CHARGES	NON-COVERED CHARGES
1	0023	HH Services	HAEJ1	10012000		0 00	
2	0001					0 00	

PAYER	PROVIDER NO.	REL INFO	ASG BEN	PRIOR PAYMENTS	EST. AMOUNT DUE
Medicare	167999	Y			

DUE FROM PATIENT

INSURED'S NAME	P.REL	CERT.-SSN-HIC.-ID NO.	GROUP NAME	INSURANCE GROUP NO.
Doe, Jane M		123456789A		

TREATMENT AUTHORIZATION CODES	ESC	EMPLOYER NAME	EMPLOYER LOCATION
100120000930200001			

PRIN DIAG CD	OTHER DIAG. CODES	ADM. DIAG. CD.	E-CODE
1629			

P.C.	PRINCIPAL PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	

ATTENDING PHYS. ID: A12345 Greene, Mark
OTHER PHYS. ID:
OTHER PHYS. ID:

REMARKS:

PROVIDER REPRESENTATIVE: X Ima Clerk DATE: 10102000

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART

Claim

The Claim Contains all Line Item Details for all Visits Provided During that Episode

The claim, which is subject to the payment floor and applicable interest, is submitted at the conclusion of the 60-day episode or when the beneficiary is discharged or transferred during a 60-day period. The claim contains all line item details for all visits provided during that episode. When the claim is processed (finalized by the RHHI), a final episode payment will be generated.

Submitting a Claim

The following form locators (FLs) are required when submitting a claim. Pay particular attention to those fields that are shaded.

FL 1 **Untitled** (RT 10)	Enter the agency name and address.
FL 4 **Type of Bill** (RT 40)	Enter 329.
FL 6 **Statement Covers Period "From" and "Through" Dates** (RT 20)	Enter the effective "from" and "through" dates on the claim. The from date must be the same as the from date on the RAP. If the beneficiary has transferred to another HHA, enter the date of the last service provided to the beneficiary in the "through" field. If the beneficiary was discharged prior to the end of the 60-day episode, enter the date of discharge in the “through” field.
FL 12 **Patient Name** (RT 20)	Enter the beneficiary's last name, first name and middle initial as it appears on the Medicare health insurance card.
FL 13 **Patient Address** (RT 20)	Enter the beneficiary's address including street number and name of post office box or RFD, city, state, and zip code.

FL 14 **Birth Date** (RT 20)	Enter the beneficiary's date of birth in a MMDDCCYY format.
FL 15 **Patient Sex** (RT 20)	Enter M for male or F for female.
FL 17 **Admission Date** (RT 20)	Enter the effective date of admission. This date should match what you submitted on the RAP.
FL 20 **Source of Admission** (RT 20)	Enter **B** if this beneficiary transferred to your HHA from another HHA. Enter **C** if this beneficiary was discharged and readmitted to your HHA within a 60-day episode. If this is not a transfer situation or a discharge/readmit situation, enter the appropriate source of admission code.
FL 22 **Patient Status** (RT 20)	Enter the appropriate patient status code. If the beneficiary was discharged prior to the end of the 60-day episode, enter a patient status of 06. If you are entering a patient status code of 20, note that the statement through date on the claim must be the date of death.
FL 39-41 **Value Code(s)** (RT 41)	Enter a value code of 61 with the appropriate Metropolitan Statistical Area (MSA) code. Be sure to include the appropriate trailing zeros to make it 6 digits in length (e.g., if the MSA code is 1900, enter 190000). Enter other value codes as applicable.

FL 42 **Revenue Code** (RT 61)	Enter the appropriate revenue codes for all visits provided during the 60-day episode. Remember to include revenue code 0023 with the HIPPS Code that was listed on the RAP, and revenue code 0001 and total the charges. If the beneficiary experienced a SCIC, include additional line item(s) listing revenue code 0023 with the HIPPS Code(s) that resulted from the SCIC.
FL 44 **HCPCS/Rates** (RT 61)	Enter the HIPPS Code that was generated from the grouper software with the 0023 revenue code(s). For other revenue codes, enter the HCPCS code, if applicable, that corresponds with the service(s) being billed.
FL 45 **Service Date** (RT 61)	Enter the first billable service date for revenue code(s) 0023. For other revenue codes except supplies, enter the date the service was provided.
FL 47 **Total Charges** (RT 61)	Enter the total charge for each revenue code.
FL 48 **Noncovered Charges** (RT 61)	Use this column to show non-covered charges.
FL 50 **Payer Identification** (RT 30)	If Medicare is the primary payer, enter Medicare on line A. Enter other insurance payers on line B, if secondary, and line C, if tertiary.

FL 51 Provider Number (RT 10)	Enter your HHA provider number.
FL 52 Release of Information (RT 30)	A "Y" code indicates that your HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims. An "R" code indicates the release is limited or restricted. An "N" code indicates no release is on file.
FL 58 Insured's Name (RT 30)	Enter the name shown on the Medicare health insurance identification card. Enter the last name first using a comma or space to separate the first name from the last name.
FL 60 Cert./SSN/HIC/ID NO. (RT 30)	Enter the Medicare health insurance claim number as shown on the Medicare health insurance card.
FL 63 Treatment Authorization Code (RT 40)	**New Required Field:** Enter the OASIS matching key that is eighteen positions derived from the M0030, M0090, M0100. If a SCIC occurred during this billing period, the OASIS matching key of the last assessment should be used.
FL 67 Principal Diagnosis Code (RT 70)	Enter the principal diagnosis for which the beneficiary is receiving home health services. Be sure to use the code from the most recent coding publication. The information in this field must match the principal diagnosis indicated on the HCFA-485 and OASIS assessment. If a SCIC occurred during this billing period, this should be consistent with the final assessment.

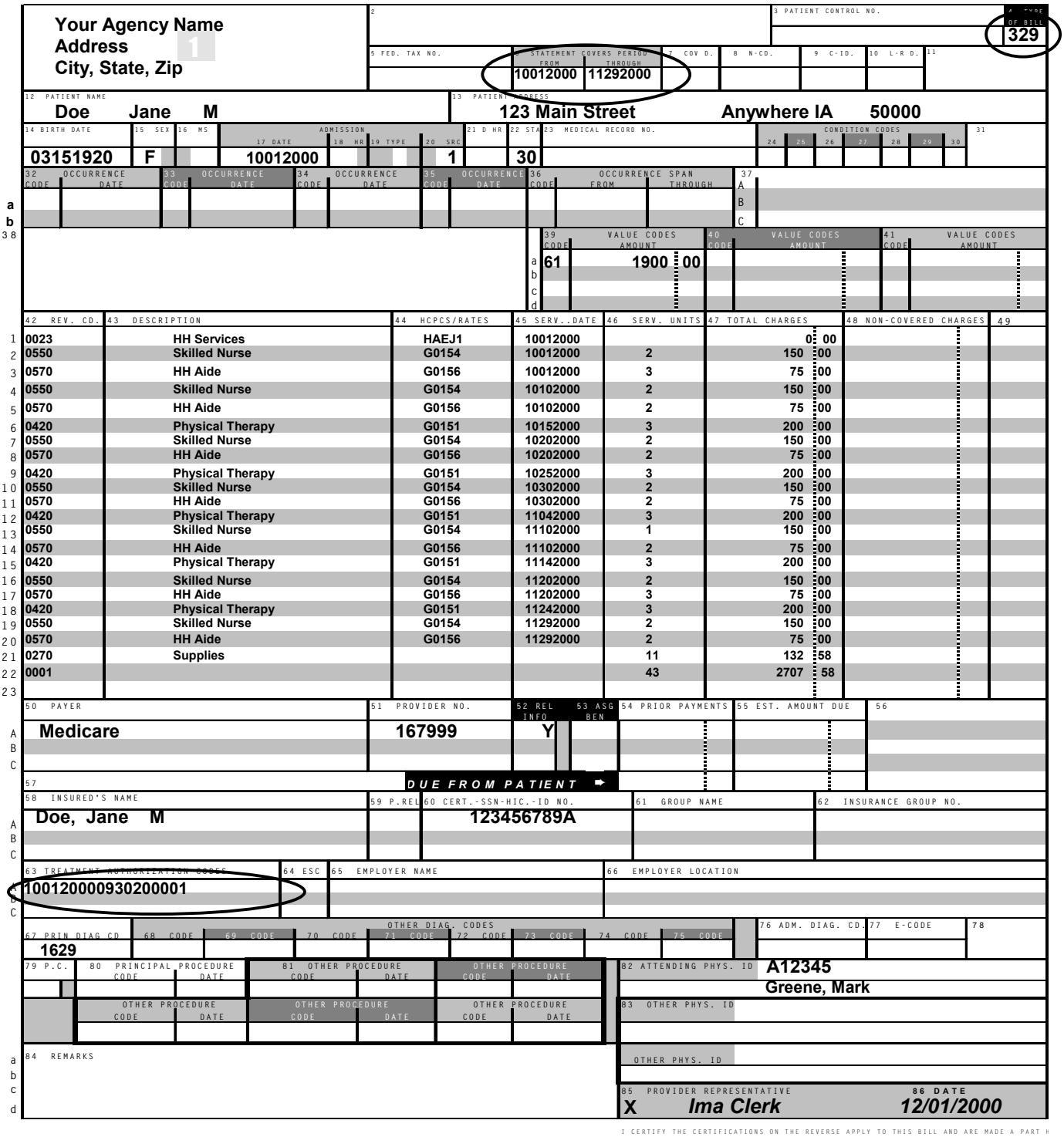
FL 68-75 **Other Diagnosis Codes** (RT 70)	Enter any other diagnosis codes for which the beneficiary was treated during this period of care. The information in these fields must match the diagnosis codes indicated on the HCFA-485 and OASIS assessment. If a SCIC occurred during this billing period, this/these should be consistent with the final assessment
FL 82 **Attending Physician ID** (RT 80)	Enter the Unique Physician Identification Number (UPIN) of the physician who has primary responsibility for the beneficiary's medical care and treatment, and the physician's last name and first initial.
FL 85 **Provider Representative**	An HHA representative must ensure that the record is accurate before signing and dating this form. A stamped signature is acceptable.

When the claim is submitted and it does not meet the criteria to be considered a No-RAP-LUPA Claim (4 or fewer visits with no RAP submitted), the system will verify that a RAP exists by matching the provider number, admit date, service from date, and first HIPPS Code on the claim to the processed RAP.

- If a match is found and the RAP is finalized, the claim will continue processing.
- If a match is found and the RAP is still processing, the system will hold the claim until the RAP finalizes and then begin processing the claim.
- If no match is found, the claim will be returned to the provider for correction.

Refer to the following pages for examples of claims.

Claim - Non Transfer Situation



Your Agency Name
Address
City, State, Zip

1 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL: 329
5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD: FROM 10012000 THROUGH 11292000 | 7 COV D. | 8 N-CD. | 9 C-ID. | 10 L-R D. | 11

12 PATIENT NAME: Doe Jane M | 13 PATIENT ADDRESS: 123 Main Street Anywhere IA 50000

14 BIRTH DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STA	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
03151920	F		10012000			1		30			

	32 OCCURRENCE CODE	DATE	33 CODE	DATE	34 CODE	DATE	35 CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
38												C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	61	1900 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0023	HH Services	HAEJ1	10012000		0 00		
2	0550	Skilled Nurse	G0154	10012000	2	150 00		
3	0570	HH Aide	G0156	10012000	3	75 00		
4	0550	Skilled Nurse	G0154	10102000	2	150 00		
5	0570	HH Aide	G0156	10102000	2	75 00		
6	0420	Physical Therapy	G0151	10152000	3	200 00		
7	0550	Skilled Nurse	G0154	10202000	2	150 00		
8	0570	HH Aide	G0156	10202000	2	75 00		
9	0420	Physical Therapy	G0151	10252000	3	200 00		
10	0550	Skilled Nurse	G0154	10302000	2	150 00		
11	0570	HH Aide	G0156	10302000	2	75 00		
12	0420	Physical Therapy	G0151	11042000	3	200 00		
13	0550	Skilled Nurse	G0154	11102000	1	150 00		
14	0570	HH Aide	G0156	11102000	2	75 00		
15	0420	Physical Therapy	G0151	11142000	3	200 00		
16	0550	Skilled Nurse	G0154	11202000	2	150 00		
17	0570	HH Aide	G0156	11202000	3	75 00		
18	0420	Physical Therapy	G0151	11242000	3	200 00		
19	0550	Skilled Nurse	G0154	11292000	2	150 00		
20	0570	HH Aide	G0156	11292000	2	75 00		
21	0270	Supplies			11	132 58		
22	0001				43	2707 58		
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare	167999	Y				
B							
C							

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, Jane M		123456789A		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A 10012000093020001			
B			
C			

67 PRIN DIAG CD	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1629											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
							A12345 Greene, Mark
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

	84 REMARKS	OTHER PHYS. ID
a		
b		
c		
d		

85 PROVIDER REPRESENTATIVE: X *Ima Clerk* | 86 DATE: *12/01/2000*

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Claim - Transfer Situation – Beneficiary Transfers to your HHA

Note Source of Admission (FL 20) is a B, which indicates that this beneficiary transferred to your HHA from another HHA.

Your Agency Name
Address
City, State, Zip

3 PATIENT CONTROL NO.
4 TYPE OF BILL: 329

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM: 10012000 THROUGH: 11292000 | 7 COV D. | 8 N-CD. | 9 C-ID. | 10 L-R D. | 11

12 PATIENT NAME: Doe Jane M
13 PATIENT ADDRESS: 123 Main Street Anywhere IA 50000

14 BIRTH DATE: 03151920 | 15 SEX: F | 16 MS | ADMISSION 17 DATE: 10012000 | 18 HR | 19 TYPE | 20 SRC: B | 21 D HR | 22 STAT: 30 | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38

39 VALUE CODES CODE AMOUNT: a 61 1900 00 | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0023	HH Services	HAEJ1	10012000		0 00		
2	0550	Skilled Nurse	G0154	10012000	2	150 00		
3	0570	HH Aide	G0156	10012000	3	75 00		
4	0550	Skilled Nurse	G0154	10102000	2	150 00		
5	0570	HH Aide	G0156	10102000	2	75 00		
6	0420	Physical Therapy	G0151	10152000	3	200 00		
7	0550	Skilled Nurse	G0154	10202000	2	150 00		
8	0570	HH Aide	G0156	10202000	2	75 00		
9	0420	Physical Therapy	G0151	10252000	3	200 00		
10	0550	Skilled Nurse	G0154	10302000	2	150 00		
11	0570	HH Aide	G0156	10302000	2	75 00		
12	0420	Physical Therapy	G0151	11042000	3	200 00		
13	0550	Skilled Nurse	G0154	11102000	1	150 00		
14	0570	HH Aide	G0156	11102000	2	75 00		
15	0420	Physical Therapy	G0151	11142000	3	200 00		
16	0550	Skilled Nurse	G0154	11202000	2	150 00		
17	0570	HH Aide	G0156	11202000	3	75 00		
18	0420	Physical Therapy	G0151	11242000	3	200 00		
19	0550	Skilled Nurse	G0154	11292000	2	150 00		
20	0570	HH Aide	G0156	11292000	2	75 00		
21	0270	Supplies			11	132 58		
22	0001				43	2707 58		
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare	167999	Y				
B							
C							

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane M		123456789A		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	100120000930200001			
B				
C				

67 PRIN DIAG CD: 1629 | OTHER DIAG. CODES 68 CODE | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID: A12345 Greene, Mark

83 OTHER PHYS. ID

OTHER PHYS. ID

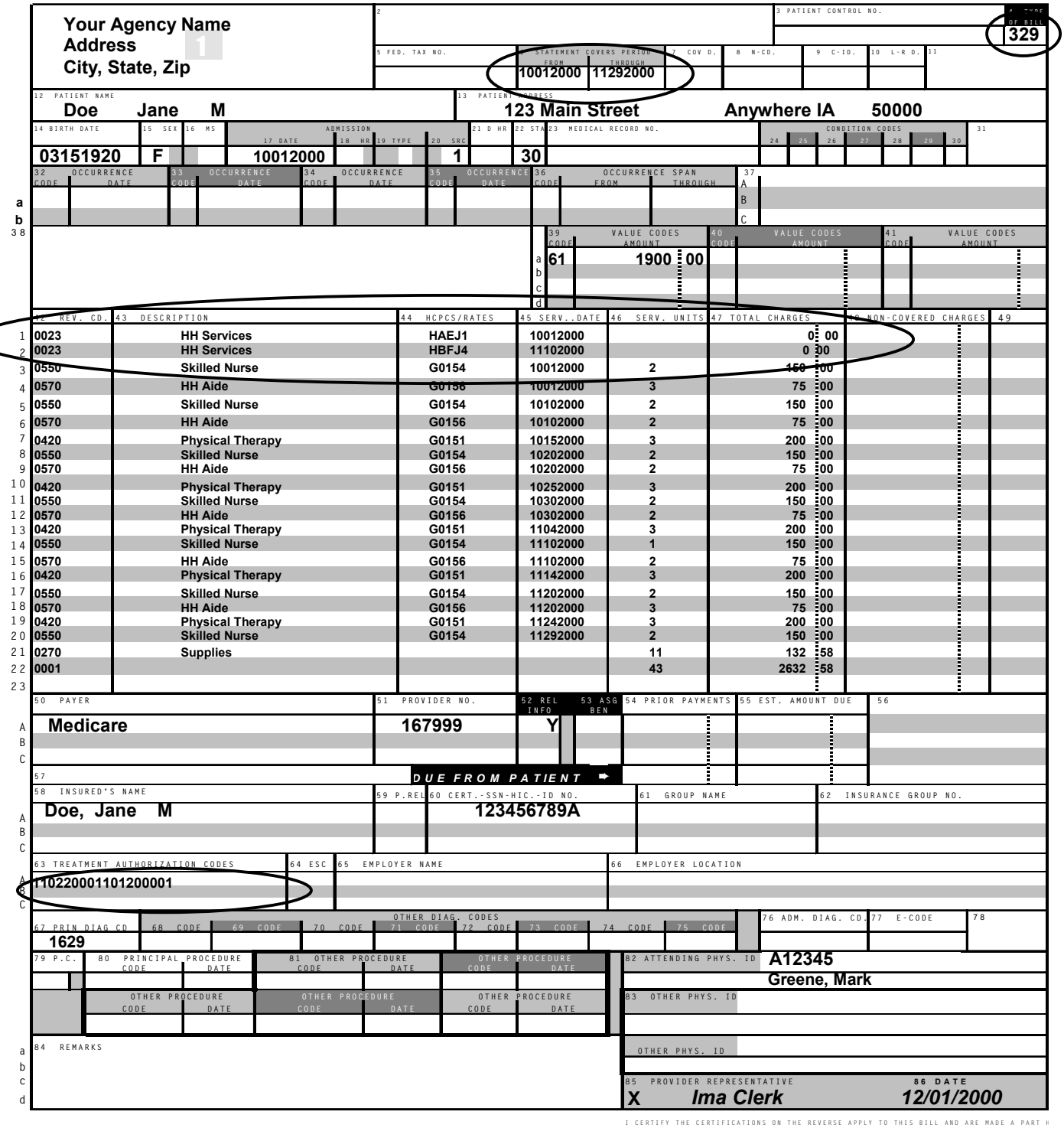
84 REMARKS a b c d

85 PROVIDER REPRESENTATIVE: X *Ima Clerk* | 86 DATE: *12/01/2000*

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Claim - SCIC Situation

Note that two HIPPS Codes appear on this claim due to a SCIC.



Your Agency Name
Address
City, State, Zip

1 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL: 329

5 FED. TAX NO. | STATEMENT COVERS PERIOD FROM: 10012000 THROUGH: 11292000 | 7 COV D. | 8 N-CD. | 9 C-ID. | 10 L-R D. | 11

12 PATIENT NAME: Doe Jane M | 13 PATIENT ADDRESS: 123 Main Street Anywhere IA 50000

14 BIRTH DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STA	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
03151920	F		10012000			1		30			

	32 OCCURRENCE CODE	DATE	33 CODE	DATE	34 CODE	DATE	35 CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	61	1900 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0023	HH Services	HAEJ1	10012000		0 00		
2	0023	HH Services	HBFJ4	11102000		0 00		
3	0550	Skilled Nurse	G0154	10012000	2	150 00		
4	0570	HH Aide	G0156	10012000	3	75 00		
5	0550	Skilled Nurse	G0154	10102000	2	150 00		
6	0570	HH Aide	G0156	10102000	2	75 00		
7	0420	Physical Therapy	G0151	10152000	3	200 00		
8	0550	Skilled Nurse	G0154	10202000	2	150 00		
9	0570	HH Aide	G0156	10202000	2	75 00		
10	0420	Physical Therapy	G0151	10252000	3	200 00		
11	0550	Skilled Nurse	G0154	10302000	2	150 00		
12	0570	HH Aide	G0156	10302000	2	75 00		
13	0420	Physical Therapy	G0151	11042000	3	200 00		
14	0550	Skilled Nurse	G0154	11102000	1	150 00		
15	0570	HH Aide	G0156	11102000	2	75 00		
16	0420	Physical Therapy	G0151	11142000	3	200 00		
17	0550	Skilled Nurse	G0154	11202000	2	150 00		
18	0570	HH Aide	G0156	11202000	3	75 00		
19	0420	Physical Therapy	G0151	11242000	3	200 00		
20	0550	Skilled Nurse	G0154	11292000	2	150 00		
21	0270	Supplies			11	132 58		
22	0001				43	2632 58		
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare	167999	Y				
B							
C							

57 DUE FROM PATIENT ➡

	58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane M		123456789A		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B	110220001101200001			
C				

67 PRIN DIAG CD	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1629											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID: A12345 Greene, Mark
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

	84 REMARKS	OTHER PHYS. ID
a		
b		
c		
d		85 PROVIDER REPRESENTATIVE: X Ima Clerk — 86 DATE: 12/01/2000

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Claim – No-RAP-LUPA Claim

In this example, the beneficiary transferred to another HHA. Your HHA provided two services and had not yet submitted the RAP when the beneficiary transferred; therefore, you have a No-RAP-LUPA Claim situation.

Field	Entry
1	
2	
3 PATIENT CONTROL NO.	
4 TYPE OF BILL	329
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM	10012000
6 STATEMENT COVERS PERIOD THROUGH	10032000
7 COV D.	
8 N-CD.	
9 C-ID.	
10 L-R D.	
11	
12 PATIENT NAME	Doe Jane M
13 PATIENT ADDRESS	123 Main Street Anywhere IA 50000
14 BIRTH DATE	03151920
15 SEX	F
16 MS	
ADMISSION 17 DATE	10012000
18 HR	
19 TYPE	1
20 SRC	
21 D HR	
22 STAT	06
23 MEDICAL RECORD NO.	
CONDITION CODES 24–30	
31	
32–35 OCCURRENCE CODE / DATE (a, b)	
36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37 A, B, C	
38	
39 VALUE CODES CODE / AMOUNT (a)	61 / 1900 00
40 VALUE CODES CODE / AMOUNT	
41 VALUE CODES CODE / AMOUNT	

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0023	HH Services	HAEJ1	10012000		0 00		
2	0550	Skilled Nurse	G0154	10012000	2	150 00		
3	0570	HH Aide	G0156	10012000	3	75 00		
4								
5	0001				5	225 00		
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare	167999		Y			
B							
C							

57 DUE FROM PATIENT ➨

	58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane M		123456789A		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	100120000930200001			
B				
C				

Field	Entry
67 PRIN DIAG CD	1629
OTHER DIAG. CODES 68–75 CODE	
76 ADM. DIAG. CD.	
77 E-CODE	
78	
79 P.C.	
80 PRINCIPAL PROCEDURE CODE / DATE	
81 OTHER PROCEDURE CODE / DATE	
OTHER PROCEDURE CODE / DATE	
82 ATTENDING PHYS. ID	A12345 Greene, Mark
83 OTHER PHYS. ID	
OTHER PHYS. ID	
84 REMARKS (a, b, c, d)	
85 PROVIDER REPRESENTATIVE	X Ima Clerk
86 DATE	10/10/2000

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Adjusting a Claim

If incorrect information is entered on the claim, the claim can be adjusted or cancelled (provided that it has not been partially or fully denied). This section discusses provider generated claim adjustments. The next section discusses claim cancellations.

The following form locators (FLs) are required when **adjusting** a claim. Pay particular attention to those fields that are shaded.

FL 1 **Untitled** (RT 10)	Enter the agency name and address.
FL 4 **Type of Bill** (RT 40)	Enter 327.
FL 6 **Statement Covers Period "From" and "Through" Dates** (RT 20)	Enter the appropriate "from" and "through" dates.
FL 12 **Patient Name** (RT 20)	Enter the beneficiary's last name, first name and middle initial as it appears on the Medicare health insurance card.
FL 13 **Patient Address** (RT 20)	Enter the beneficiary's address including street number and name of post office box or RFD, city, state, and zip code.
FL 14 **Birth Date** (RT 20)	Enter the beneficiary's date of birth in a MMDDCCYY format.

FL 15 **Patient Sex** (RT 20)	Enter M for male or F for female.
FL 17 **Admission Date** (RT 20)	Enter the effective date of admission.
FL 20 **Source of Admission** (RT 20)	Enter the appropriate source of admission code.
FL 22 **Patient Status** (RT 20)	Enter the appropriate patient status code.
FL 24-30 **Condition Codes** (RT 41)	Enter the appropriate claim change reason code: D0 - Changes to Service Dates D1 - Changes to Charges D2- Change in Revenue Code/HCPCS D7 - Change to make Medicare Secondary Payer D8 - Change to make Medicare Primary Payer D9 - Any other change or multiple changes (remarks required) E0 - Change in patient status If the HIPPS Code is being changed, use condition code D9.
FL 37 **Internal Control Number or Document Control Number** (RT 31)	Enter the Intermediary's control number on the claim being adjusted. This number can be found on the remittance advice listing the original processed claim.

FL 39-41 **Value Code(s)** (RT 41)	Enter the appropriate MSA code. Enter other value codes as applicable.
FL 42 **Revenue Code** (RT 61)	Enter the applicable revenue codes.
FL 44 **HCPCS/Rates** (RT 61)	Enter the applicable HIPPS Codes, HCPCS and rates.
FL 45 **Service Date** (RT 61)	Enter the applicable service dates.
FL 47 **Total Charges** (RT 61)	Enter the total charges.
FL 48 **Noncovered Charges** (RT 61)	Use this column to show non-covered charges.
FL 50 **Payer Identification** (RT 30)	If Medicare is the primary payer, enter Medicare on line A. Enter other insurance payers on line B, if secondary, and line C, if tertiary.
FL 51 **Provider Number** (RT 10)	Enter your HHA provider number.
FL 52 **Release of Information** (RT 30)	A "Y" code indicates that your HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims. An "R" code indicates the release is limited or restricted. An "N" code indicates no release is on file.

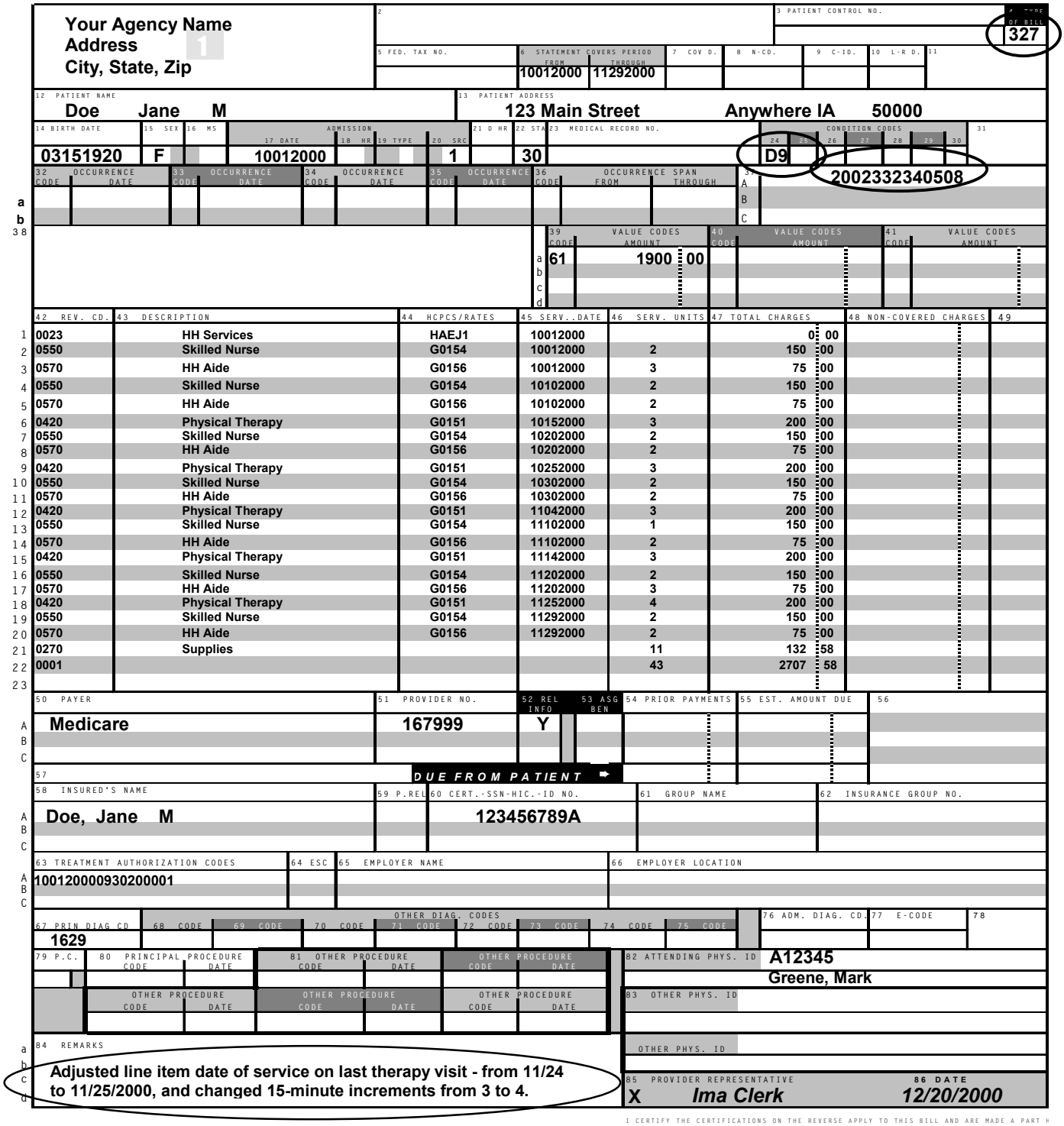
FL 58 Insured's Name (RT 30)	Enter the name shown on the Medicare health insurance identification card. Enter the last name first using a comma or space to separate the first name from the last name.
FL 60 Cert./SSN/HIC/ID NO. (RT 30)	Enter the Medicare health insurance claim number as shown on the Medicare health insurance card.
FL 63 Treatment Authorization Code (RT 40)	**New Required Field:** Enter the OASIS matching key that is eighteen positions derived from the M0030, M0090, M0100.
FL 67 Principal Diagnosis Code (RT 70)	Enter the principal diagnosis for which the beneficiary is receiving home health services. Be sure to use the code from the most recent coding publication. The information in this field must match the principal diagnosis indicated on the HCFA-485 and OASIS assessment.
FL 68-75 Other Diagnosis Codes (RT 70)	Enter any other diagnosis codes for which the beneficiary was treated during this period of care. The information in these fields must match the other diagnosis codes indicated on the HCFA-485 and OASIS assessment.
FL 82 Attending Physician ID (RT 80)	Enter the Unique Physician Identification Number (UPIN) of the physician who has primary responsibility for the beneficiary's medical care and treatment, and the physician's last name and first initial.

FL 84 Remarks (RT 91)	If you use a claim change reason of D9 on the adjustment, remarks are required.
FL 85 Provider Representative	An HHA representative must ensure that the record is accurate before signing and dating this form. A stamped signature is acceptable.

Refer to the following page for an example of an adjusted Claim.

Claim- Adjustment

Note that the type of bill changes to end in a 7, a Claim Change Reason Code (e.g., D9) is included, and the RHHI's Internal Control Number that identifies the original Claim is included. Remarks are noted in FL 84 at the bottom of the claim.



Your Agency Name
Address
City, State, Zip

3 PATIENT CONTROL NO.
4 TYPE OF BILL: 327
6 STATEMENT COVERS PERIOD: FROM 10012000 THROUGH 11292000

12 PATIENT NAME: Doe Jane M
13 PATIENT ADDRESS: 123 Main Street Anywhere IA 50000

14 BIRTH DATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STA	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
03151920	F		10012000			1		30		D9							

2002332340508

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	61	1900 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0023	HH Services	HAEJ1	10012000		0 00		
2	0550	Skilled Nurse	G0154	10012000	2	150 00		
3	0570	HH Aide	G0156	10012000	3	75 00		
4	0550	Skilled Nurse	G0154	10102000	2	150 00		
5	0570	HH Aide	G0156	10102000	2	75 00		
6	0420	Physical Therapy	G0151	10152000	3	200 00		
7	0550	Skilled Nurse	G0154	10202000	2	150 00		
8	0570	HH Aide	G0156	10202000	2	75 00		
9	0420	Physical Therapy	G0151	10252000	3	200 00		
10	0550	Skilled Nurse	G0154	10302000	2	150 00		
11	0570	HH Aide	G0156	10302000	2	75 00		
12	0420	Physical Therapy	G0151	11042000	3	200 00		
13	0550	Skilled Nurse	G0154	11102000	1	150 00		
14	0570	HH Aide	G0156	11102000	2	75 00		
15	0420	Physical Therapy	G0151	11142000	3	200 00		
16	0550	Skilled Nurse	G0154	11202000	2	150 00		
17	0570	HH Aide	G0156	11202000	3	75 00		
18	0420	Physical Therapy	G0151	11252000	4	200 00		
19	0550	Skilled Nurse	G0154	11292000	2	150 00		
20	0570	HH Aide	G0156	11292000	2	75 00		
21	0270	Supplies			11	132 58		
22	0001				43	2707 58		
23								

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicare	167999	Y				
B						
C						

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, Jane M		123456789A		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A 100120000930200001			
B			
C			

67 PRIN DIAG CD	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1629											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: A12345 Greene, Mark
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS

a b c d: Adjusted line item date of service on last therapy visit - from 11/24 to 11/25/2000, and changed 15-minute increments from 3 to 4.

85 PROVIDER REPRESENTATIVE: X Ima Clerk
86 DATE: 12/20/2000

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Canceling a Claim

Canceling a claim cancels the episode on CWF. Refer to the Transaction Matrix at the end of this chapter, which explains how CWF is impacted by PPS transactions submitted to the RHHI.

The following form locators (FLs) are required when the provider is **canceling** a claim. Pay particular attention to those fields that are shaded.

FL 1 **Untitled** (RT 10)	Enter the agency name and address.
FL 4 **Type of Bill** (RT 40)	Enter 328.
FL 6 **Statement Covers Period "From" and "Through" Dates** (RT 20)	Enter the from and through date. Make sure this matches the original Claim.
FL 12 **Patient Name** (RT 20)	Enter the beneficiary's last name, first name and middle initial as it appears on the Medicare health insurance card.
FL 13 **Patient Address** (RT 20)	Enter the beneficiary's address including street number and name of post office box or RFD, city, state, and zip code.
FL 14 **Birth Date** (RT 20)	Enter the beneficiary's date of birth in a MMDDCCYY format.
FL 15 **Patient Sex** (RT 20)	Enter M for male or F for female.

FL 17 **Admission Date** (RT 20)	Enter the effective date of admission. Make sure this matches the original claim.
FL 20 **Source of Admission** (RT 20)	Enter the appropriate source of admission code. Make sure this matches the original claim.
FL 22 **Patient Status** (RT 20)	Enter the appropriate patient status code. Make sure this matches the original claim.
FL 24-30 **Condition Codes** (RT 41)	Enter the appropriate claim change reason code: D5 - cancel to correct HICN or provider number; D6 - cancel duplicate or OIG overpayment.
FL 37 **Internal Control Number or Document Control Number** (RT 31)	Enter the Intermediary's control number on the claim being adjusted. This number can be found on the remittance advice listing the original processed claim.
FL 39-41 **Value Code(s)** (RT 41)	Enter the MSA Code. Enter other value codes as applicable.
FL 42 **Revenue Code** (RT 61)	Enter the appropriate revenue codes. Make sure the revenue code page matches the original claim.
FL 44 **HCPCS/Rates** (RT 61)	Enter the applicable HIPPS Codes, HCPCS and rates. Make sure this matches the original claim.
FL 45 **Service Date** (RT 61)	Enter applicable service dates. Make sure this matches the original claim.

FL 47 **Total Charges** (RT 61)	Enter the total charges. Make sure your charges equal the charges submitted on the original Claim.
FL 48 **Noncovered Charges** (RT 61)	Use this column to show non-covered charges.
FL 50 **Payer Identification** (RT 30)	If Medicare is the primary payer, enter Medicare on line A. Enter other insurance payers on line B, if secondary, and line C, if tertiary.
FL 51 **Provider Number** (RT 10)	Enter your HHA provider number.
FL 52 **Release of Information** (RT 30)	A "Y" code indicates that your HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims. An "R" code indicates the release is limited or restricted. An "N" code indicates no release is on file.
FL 58 **Insured's Name** (RT 30)	Enter the name shown on the Medicare health insurance identification card. Enter the last name first using a comma or space to separate the first name from the last name.
FL 60 **Cert./SSN/HIC/ID NO.** (RT 30)	Enter the Medicare health insurance claim number as shown on the Medicare health insurance card.
FL 63 **Treatment Authorization Code** (RT 40)	**New required field:** Enter the OASIS matching key that is eighteen positions derived from the M0030, M0090, M0100.

FL 67 **Principal Diagnosis Code** (RT 70)	Enter the principal diagnosis for which the beneficiary is receiving home health services.
FL 68-75 **Other Diagnosis Codes** (RT 70)	Enter any other diagnosis codes for which the beneficiary was treated during this period of care.
FL 82 **Attending Physician ID** (RT 80)	Enter the Unique Physician Identification Number (UPIN) of the physician who has primary responsibility for the beneficiary's medical care and treatment, and the physician's last name and first initial.
FL 85 **Provider Representative**	An HHA representative must ensure that the record is accurate before signing and dating this form. A stamped signature is acceptable.

Refer to the following page for an example of a cancelled claim.

Claim - Cancellation

Note that the type of bill changes to end in an 8, a Claim Change Reason Code (e.g., D6) is included, and the RHHI's Internal Control Number that identified the original Claim is included.

Your Agency Name
Address
City, State, Zip

3 PATIENT CONTROL NO.	A TYPE OF BILL
	328

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-CD.	9 C-ID.	10 L-R D.	11
	10012000	11292000					

12 PATIENT NAME			13 PATIENT ADDRESS		
Doe	Jane	M	123 Main Street	Anywhere IA	50000

14 BIRTH DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
03151920	F		10012000			1		30		D6	

32 OCCURRENCE CODE	DATE	33 CODE	DATE	34 CODE	DATE	35 CODE	DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

2002332340508

38

39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a 61	1900 00				
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV..DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0023	HH Services	HAEJ1	10012000		0 00		
2	0550	Skilled Nurse	G0154	10012000	2	150 00		
3	0570	HH Aide	G0156	10012000	3	75 00		
4	0550	Skilled Nurse	G0154	10102000	2	150 00		
5	0570	HH Aide	G0156	10102000	2	75 00		
6	0420	Physical Therapy	G0151	10152000	3	200 00		
7	0550	Skilled Nurse	G0154	10202000	2	150 00		
8	0570	HH Aide	G0156	10202000	2	75 00		
9	0420	Physical Therapy	G0151	10252000	3	200 00		
10	0550	Skilled Nurse	G0154	10302000	2	150 00		
11	0570	HH Aide	G0156	10302000	2	75 00		
12	0420	Physical Therapy	G0151	11042000	3	200 00		
13	0550	Skilled Nurse	G0154	11102000	1	150 00		
14	0570	HH Aide	G0156	11102000	2	75 00		
15	0420	Physical Therapy	G0151	11142000	3	200 00		
16	0550	Skilled Nurse	G0154	11202000	2	150 00		
17	0570	HH Aide	G0156	11202000	3	75 00		
18	0420	Physical Therapy	G0151	11252000	4	200 00		
19	0550	Skilled Nurse	G0154	11292000	2	150 00		
20	0570	HH Aide	G0156	11292000	2	75 00		
21	0270	Supplies			11	132 58		
22	0001				43	2707 58		
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare	167999	Y				
B							
C							

57 DUE FROM PATIENT ➡

	58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane M		123456789A		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	100120000930200001			
B				
C				

67 PRIN DIAG CD	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1629											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: A12345
Greene, Mark

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a b c d	X *Ima Clerk*	*12/20/2000*

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART H

Submitting Claims on October 1, 2000

OASIS Start of Care or Follow-Up

If a beneficiary is under an established HH Plan of Care before October 1, 2000, and the HHA has completed a Start of Care or Follow-Up OASIS earlier than September 1, 2000, the HHA must complete a one-time additional Follow-Up OASIS any time during the month of September in order to group the beneficiary for purposes of case-mix classification. This is a one-time grace period. After October 1, 2000, an OASIS assessment must be completed during the last 5 days of the certification period in order to case-mix adjust the patient for subsequent episode certification.

If a beneficiary is under an established HH Plan of Care before October 1, 2000, and the HHA has completed a start of care or follow-up OASIS on or after September 1, 2000, and does not wish to do a one-time OASIS at the inception of PPS, the HHA may use the earlier OASIS assessment.

OASIS Start of Care or Follow-Up	
OASIS completed earlier than 09/01/2000?	One-time additional follow-up OASIS during September
OASIS completed after 09/01/2000?	No additional follow-up OASIS required; earlier OASIS assessment (i.e., occurring between 09/01 and 09/30) can be used

Physician Plan of Care Dates

If a beneficiary is under an established HH Plan of Care before October 1, 2000, and the certification date is earlier than September 1, 2000, the HHA in conjunction with a certifying physician must complete a one-time additional recertification of the Plan of Care before the inception of PPS on October 1, 2000.

If a beneficiary is under an established HH Plan of Care before October 1, 2000, and the certification date is on or after September 1, 2000, and the HHA in conjunction with a certifying physician does not wish to do a one-time additional recertification of the Plan of Care at the inception of PPS, the HHA may use the recertification date (September 1, 2000 through September 30, 2000) from the earlier version of the Plan of Care. This is a one-time grace period.

For example, an eligible beneficiary under a Plan of Care has a Medicare start of care date equal to September 15, 2000. The one-time grace period would reflect a Plan of Care that specifies physician orders for services furnished both before and after implementation of HH PPS. The physician orders in the Plan of Care would reflect services from September 15, 2000 through and including September 30, 2000. All current coverage and payment rules would apply to the services provided on September 15, 2000 through and including September 30, 2000. The Plan of Care would also specify any services ordered on October 1, 2000 through and including November 29, 2000. The Plan of Care would reflect the break in services both before and after implementation of HH PPS. The start of care date/first billable visit date for this beneficiary under PPS in the Plan of Care is October 1, 2000.

Physician Certification	
Cert. date earlier than 09/01/2000?	One-time additional recertification of the Plan of Care before 10/01/2000
Cert. date after 09/01/2000?	Recertification date from earlier version of the Plan of Care may be used if it falls between 09/01 and 09/30.

Services Spanning September/October, 2000

Claims cannot span both payment systems. Therefore, cost reimbursement claims must contain services from 9/30/2000 or before. HH PPS claims must contain services from 10/01/2000 and after. Cost reimbursement claims can continue to be submitted for as long as current requirements on timely submission allow (up to 27 months).

Payment Responsibility in HMO Situations

If the beneficiary is covered under an HMO during care and subsequently elects to be covered under Medicare Fee-for-Service coverage, a new OASIS must be completed. A new OASIS is required whenever the payer source changes.
If the beneficiary elects HMO coverage during the 60-day episode, the 60-day episode payment will be proportionally adjusted with a PEP. The agency will submit a claim indicating the last billable visit date (prior to the HMO election) as the "through" date in FL 6 on the UB-92. The HMO becomes the primary payer upon the HMO election date.

POST SUBMISSION INFORMATION

A/B Shift

Although the A/B shift will continue to happen, claims will no longer be split in the claims processing system. Instead, the value code fields will be automatically populated by the system to indicate whether the charges were paid out of the Part A trust fund, the Part B trust fund or both.

- If all the visits on the claim are Part A, a value code of 62 will appear on the claim indicating the number of visits paid under the Part A portion of Medicare and the full episode payment will be listed with value code 64.
- If all the visits on the claim are Part B, a value code of 63 will appear on the claim indicating the number of visits paid under the Part B portion of Medicare and the full episode payment will be listed with value code 65.

- If the visits on the claim are split between the Part and Part B trust funds, the system will prorate the episode payment on the basis of the number of visits with value code 64 representing the Part A amount and value code 65 representing the Part B amount.

Reimbursement Amount

When a RAP is finalized in the system in a paid status, reimbursement will be listed in the total charges field of the 0023 revenue code line. The total charges listed on the 0001 revenue code line will match the amount listed on the 0023 revenue code line.

When a claim is finalized in the system in a paid status, PPS reimbursement will be listed in the total charges field of the 0023 revenue code line. The summary of charges will appear in the total charges field of the 0001 revenue code line, but this total will not include the amount listed in the 0023 revenue code line.

Remittance Advice

The remittance advice will display the reimbursement amount in the 0023 revenue code line.
Reimbursement of the claim will appear on the remittance advice as a debit/credit adjustment to the episode payment originally made on the RAP.

The following versions of the electronic remittance advice (ERA) are currently accepted:

- ERA Version 3051.4A
- ERA Version 3051.3A
- ERA Version 3030.M2

CHAPTER SUMMARY/REVIEW

HIPPS Codes

- Generated from grouper software within HAVEN
- Placed on all RAPs (which will have only one HIPPS code) and claims
- Associated with revenue code 0023

60-day Episode

- Corresponds with OASIS and Plan of Care requirements
- Begins on first Medicare billable visit; ends on and includes 60th day from the first billable visit date
- No limit to number of recertified 60-day episodes in a fiscal year provided that beneficiary meets requirements
- Episode ends when beneficiary elects transfer or is discharged (even if beneficiary returns to HHA within same 60-day episode)
- Episode does not end when beneficiary experiences SCIC

Payment Provisions

- PEP Adjustment occurs when beneficiary transfers or is discharged (all goals met) and readmitted to the same HHA prior to the end of the 60-day episode
- SCIC Adjustment occurs when beneficiary experiences a change in condition that ultimately results in a new HIPPS code
- LUPAs occur when an HHA provides four or fewer visits during a 60-day episode
- When submitting an initial RAP and a claim, payment is disbursed in a 60/40 split. When submitting subsequent RAPs and claims, payment is disbursed in a 50/50 split.
- Outlier payments may be made when an HHA incurs extraordinary costs beyond the regular episode payment
- The HHA establishing the Plan of Care has the responsibility for billing all Medicare-covered home health services

Submission Instructions

RAPs

- Not subject to payment floor
- Type of Bill is 322
- Includes basic beneficiary information, MSA code, source of admission code, patient status code, diagnosis code(s), and UPIN
- From and through dates are the same date
- Includes one revenue code 0023 and HIPPS Code
- Other revenue code information acceptable if software requires it, but this information will be ignored by claims processing system
- Cancellation of RAP allowed

Claims

- RAP must be submitted prior to submission of claim (see No-RAP-LUPA claim exception below)
- Subject to payment floor and applicable interest
- Type of Bill is 329
- Includes basic beneficiary information, MSA code, other applicable value codes, condition codes, etc., source of admission code, patient status code, diagnosis code(s), UPIN, etc.
- Includes revenue code(s) 0023 and HIPPS Code(s)
- Includes all line item details for all visits provided during episode
- Adjustment/Cancellation of claim allowed
- Appeal rights apply to claims only, and not RAPs

No-RAP-LUPA Claims

- RAP not required; beneficiary received 4 or fewer visits
- Adjustment/Cancellation of No-RAP-LUPA claim allowed. If visits are being added to the claim that would result in more than 4 visits in the episode, then the No-RAP-LUPA claim must be cancelled and a RAP submitted.
- Payment is per visit, not PPS.

Submitting Claims on October 1, 2000

- All open bills for services provided September 30, 2000, and earlier must be closed
- If OASIS follow-up prior to September 1, 2000, the HHA must complete a one-time additional follow-up OASIS
- If OASIS follow-up on or after September 1, 2000, the HHA does not have to do an additional follow-up OASIS
- Plan of Care must be recertified if the certification date is before September 1, 2000
- Plan of Care does not need to be recertified if the certification date is on or after September 1, 2000 and dates may extend up to 11/29/00 (60 days from 10/01/2000)

Additional Information

- A/B shift identified on claim by value codes; claims will not be split
- Reimbursement of claim appears on remittance advice as a debit/credit adjustment
- Medicare will make secondary payments on claims only, not on RAPs. Providers may wish to track primary payer services in the same 60-day increments.
- HCFA will clarify the status of demand billing at a future date.

NON-ROUTINE MEDICAL SUPPLIES

A4212	Non coring needle or stylet
A4213	20+ CC syringe only
A4215	Sterile needle
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way
A4320	Irrigation tray
A4321	Cath therapeutic irrig agent
A4322	Irrigation syringe
A4323	Saline irrigation solution
A4326	Male external catheter
A4327	Fem urinary collect dev cup
A4328	Fem urinary collect pouch
A4329	External catheter start set
A4330	Stool collection pouch
A4335	Incontinence supply
A4338	Indwelling catheter latex
A4340	Indwelling catheter special
A4344	Cath indw foley 2 way silicn
A4346	Cath indw foley 3 way
A4347	Male external catheter

A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing
A4356	Ext ureth clmp or compr dvc
A4357	Bedside drainage bag
A4358	Urinary leg bag
A4359	Urinary suspensory w/o leg bag
A4361	Ostomy face plate
A4362	Solid skin barrier
A4363	Liquid skin barrier
A4364	Ostomy/cath adhesive
A4365	Ostomy adhesive remover wipe
A4367	Ostomy belt
A4368	Ostomy filter
A4397	Irrigation supply sleeve
A4398	Ostomy irrigation bag
A4399	Ostomy irrig cone/cath w brs
A4400	Ostomy irrigation set
A4402	Lubricant per ounce
A4404	Ostomy ring each
A4421	Ostomy supply misc
A4455	Adhesive remover per ounce
A4554	Disposable underpads, all sizes
A4460	Elastic compression bandage
A4462	Abdmnl drssng holder/binder
A4481	Tracheostoma filter

A4622	Tracheostomy or larngectomy
A4623	Tracheostomy inner cannula
A4625	Trach care kit for new trach
A4626	Tracheostomy cleaning brush
A4649	Surgical supplies
A5051	Pouch clsd w barr attached
A5052	Clsd ostomy pouch w/o barr
A5053	Clsd ostomy pouch faceplate
A5054	Clsd ostomy pouch w/flange
A5055	Stoma cap
A5061	Pouch drainable w barrier at
A5062	Drnble ostomy pouch w/o barr
A5063	Drain ostomy pouch w/flange
A5071	Urinary pouch w/barrier
A5072	Urinary pouch w/o barrier
A5073	Urinary pouch on barr w/flng
A5081	Continent stoma plug
A5082	Continent stoma catheter
A5093	Ostomy accessory convex inse
A5102	Bedside drain btl w/wo tube
A5105	Urinary suspensory
A5112	Urinary leg bag
A5113	Latex leg strap
A5114	Foam/fabric leg strap
A5119	Skin barrier wipes box pr 50
A5121	Solid skin barrier 6x6
A5122	Solid skin barrier 8x8
A5123	Skin barrier with flange

A5126	Disk/foam pad +or- adhesive
A5131	Appliance cleaner
A5149	Incontinence/ostomy supply
A6020	Collagen wound dressing
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	Alginate dressing > 48 sq in
A6199	Alginate drsg wound filler
A6200	Compos drsg <=16 no bdr
A6201	Compos drsg >16<=48 no bdr
A6202	Compos drsg >48 no bdr
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/bdr
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/bdr
A6215	Foam dressing wound filler
A6219	Gauze <= 16 sq in w/bdr
A6220	Gauze >16 <=48 sq in w/bdr
A6221	Gauze > 48 sq in w/bdr

A6222 Gauze <=16 in no w/sal w/o b

A6223 Gauze >16<=48 no w/sal w/o b

A6224 Gauze > 48 in no w/sal w/o b

A6228 Gauze <= 16 sq in water/sal

A6229 Gauze >16<=48 sq in watr/sal

A6230 Gauze > 48 sq in water/salne

A6234 Hydrocolld drg <=16 w/o bdr

A6235 Hydrocolld drg >16<=48 w/o b

A6236 Hydrocolld drg > 48 in w/o b

A6237 Hydrocolld drg <=16 in w/bdr

A6238 Hydrocolld drg >16<=48 w/bdr

A6239 Hydrocolld drg > 48 in w/bdr

A6240 Hydrocolld drg filler paste

A6241 Hydrocolloid drg filler dry

A6242 Hydrogel drg <=16 in w/o bdr

A6243 Hydrogel drg >16<=48 w/o bdr

A6244 Hydrogel drg >48 in w/o bdr

A6245 Hydrogel drg <= 16 in w/bdr

A6246 Hydrogel drg >16<=48 in w/b

A6247 Hydrogel drg > 48 sq in w/b

A6248 Hydrogel dressing, wound filler

A6251 Absorpt drg <=16 sq in w/o b

A6252 Absorpt drg >16 <=48 w/o bdr

A6253 Absorpt drg > 48 sq in w/o b

A6254 Absorpt drg <=16 sq in w/bdr

A6255 Absorpt drg >16<=48 in w/bdr

A6256 Absorpt drg > 48 sq in w/bdr

A6257 Transparent film <= 16 sq in

A6258	Transparent film >16<=48 in
A6259	Transparent film > 48 sq in
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram
A6266	Impreg gauze no h20/sal/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6405	Sterile elastic gauze /yd
A6406	Sterile non-elastic gauze/yd
K0277	Skin barrier solid 4x4 equiv
K0278	Skin barrier with flange
K0279	Skin barrier extended wear
K0280	Extension drainage tubing
K0281	Lubricant catheter insertion
K0407	Urinary cath skin attachment
K0408	Urinary cath leg strap
K0409	Sterile H2O irrigation solut
K0410	Male ext cath w/adh coating
K0411	Male ext cath w/adh strip
K0419	Drainable plstic pch w fcplt
K0420	Drainable rubber pch w fcplt
K0421	drainable plstic pch w/o fp
K0422	Drainable rubber pch w/o fp
K0423	Urinary plstic pouch w fcplt
K0424	Urinary rubber pouch w fcplt
K0425	Urinary plstic pouch w/o fp
K0426	Urinary hvy plstc pch w/o fp

K0427	Urinary rubber pouch w/o fp
K0428	Ostomy faceplt/silicone ring
K0429	Skin barrier solid ext wear
K0430	Skin barrier w flang ex wear
K0431	Closed pouch w st wear bar
K0432	Drainable pch w ex wear bar
K0433	Drainable pch w st wear bar
K0434	Drainable pch ex wear convex
K0435	Urinary pouch w ex wear bar
K0436	Urinary pouch w st wear bar
K0437	Urine pch w ex wear bar conv
K0438	Ostomy pouch liq deodorant
K0439	Ostomy pouch solid deodorant

TRANSACTION MATRIX

The table beginning on the next page provides information about how PPS affects other providers as well as how it affects CWF information.

Transaction	How CWF is impacted	How other providers are impacted
Initial RAP	Opens a 60-day episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present
Subsequent Episode RAP	Opens another subsequent 60-day episode using RAP's "from" date; "through" date is automatically calculated to extend through next 60 days	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present
Initial RAP with Transfer Source Code of B	Opens a 60-day episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• The through date on the RAP submitted by the HHA the beneficiary is transferring from is automatically changed to reflect the "from" date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from can not bill for services past the effective date of transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs.

RAP Cancellation by Provider	60-day episode record is deleted from CWF	• 60-day episode available for RAP submission or No-RAP-LUPA Claim submission
RAP Cancellation by System	60-day episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present
Claim (full episode)	60-day episode record completed; episode "through" date remains at the 60th day; Date of Latest Billing Action (DOLBA) updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present
Claim (discharge with goals met prior to day 60)	60-day episode record completed; episode "through" date remains at the 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present
Claim (transfer)	60-day episode completed; episode "through" date reflects transfer; DOLBA updates with date of last service	• A RAP or No-RAP-LUPA claim will be accepted if the "from" date is on or after episode "through" date

No-RAP-LUPA Claim	Opens a 60-day episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • Other No-RAP-LUPA Claims will be rejected unless a transfer source code is present • Because a RAP is not submitted in this situation, until the No-RAP-LUPA claim is submitted, another provider can open a 60-day episode by submitting a RAP or by submitting a No-RAP-LUPA-claim.
Claim (adjustment)	No impact on 60-day episode unless adjustment changes patient status to transfer	• No impact
Claim Cancellation by Provider	60-day episode is deleted from CWF	• Open 60-day episode available for RAP submission or No-RAP-LUPA claim submission
Claim Cancellation by System	60-day episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present

Claim (denied)	60-day episode record completed; episode "through" date is updated if the patient status of the claim is not 01 or 30	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA Claims will be rejected unless a transfer source code is present